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ABSTRACT

A sourcebook of curriculum and teaching materials pertaining to primary prevention in mental health and social work is presented. Contents include: two articles addressing the theoretical dimensions of primary prevention and the relationship to social work education and practice; five articles describing preventive content that can be integrated into different parts of the social work educational curriculum (practice methods, social policy, research, and field instruction); and an annotated bibliography of the major interdisciplinary literature in primary prevention with particular emphasis on concepts and methods that have utility for curriculum development in primary prevention for social work. The articles and authors are as follows: "A Working Definition of Primary Prevention Related to Social Concerns," (Martin Bloom); "Conceptual Parameters of Primary Prevention," (Robert A. Porter); "Natural Helping Networks and Self-Help Groups," (Lambert Maguire); "Developmental Provision: A Prevention-Oriented Concept in Teaching Social Policy," (Risha W. Levinson); "Evaluating Programs of Primary Prevention: How Can We Know If They Make a Difference?" (Helen Reinherz); "Training in Prevention: An Educational Model for Social Work Students," (Diana Tendler and Karen Metzger); and "Integrating Services for Health Promotion," (Salvatore Ambrosino). The immediate aim of the project was to help graduate social work education programs in developing the ability to create effective policy and practice strategies to promote the delivery of preventive mental health services. (SW)

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Primary Prevention In Mental Health and Social Work

A Sourcebook of Curriculum and Teaching Materials

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Council on Social Work Education
Richard A. English, President
Arthur J. Katz, Executive Director
111 Eighth Avenue, New York, New York 10011
(212) 242-3800

FOREWORD

The Council on Social Work Education is pleased to present this collection of seven articles and an annotated bibliography dealing with primary prevention, which will serve as an aid to teachers, scholars, and practitioners in the field.

By virtue of its historical and philosophical commitment to the integrative perspective of person-in-environment as both an explanation of social problems and in guiding practice, social work has a special role to play in prevention. Yet this role has never been fully developed or even completely understood.

It is hoped that this volume will make a contribution beyond the presentation of concepts and knowledge in reawakening the consciousness of social workers to this critical dimension of their mission.

New York City
July 1981

Arthur J. Katz
Executive Director

PREFACE

This sourcebook is the first publication of the Council on Social Work Education (CSWE) in the area of curriculum development in primary prevention in mental health. It is the major product of the Project on Prevention in Social Work Education, which was supported by the National Institute of Mental Health.

In July 1978, the Council on Social Work Education was awarded a three-year grant from the National Institute of Mental Health to promote the development of curriculum and teaching materials on primary prevention in mental health. The ultimate object of the project was to increase the supply of manpower equipped to plan and deliver preventive mental health services. The immediate aim was to assist graduate social work education programs in developing the knowledge and skill needed to create effective policy and practice strategies. This aim was to be achieved through identifying and studying existing programs of class and field instruction in primary prevention in mental health and by generating new teaching materials for dissemination. The sourcebook includes the new materials developed by the project. A manual of the course outlines in primary prevention that are already being used in social work educational programs will also be made available.

The training material is also an initial response to three projects sponsored by the Council on Social Work Education that identified a need to translate the concept of primary prevention into teaching materials. In the pioneering monograph *Public Health Concepts in Social Work Education* published in 1962, Wittman noted,

> *It was generally recognized that prevention content as such is not ordinarily found in the structure of the social work curriculum. There was positive recognition of the need for more content in this area but latent confusion and uncertainty about the methods by which this might be accomplished.*[1]

In 1978, participants in the CSWE Community Mental Health Practice-Education Project agreed that prevention was an area in which "planning [in community mental health] is far in advance of operational capabilities for service delivery and [of] the educational preparation of practitioners for the delivery of new or innovative services."[2] In 1979, the National Advisory Committee of the Community Mental Health Project placed prevention first in recommending areas for the expansion of community mental health curricula.[3]

The sourcebook and the manual, which represent an implementation of these recommendations, are being disseminated at a most opportune time. In the 1978 Report of the President's Commission on Mental Health, the Task Panel on Prevention described primary prevention, with its goal of preventing emotional disorders, as the "fourth mental health revolution." The Mental Health Systems Act of October 1980 implements the recommendation of the president's commission to undertake a concentrated national effort to prevent mental disabilities. The act authorized money for projects aimed at the prevention of mental illness and the promotion of mental health. In addition, the National Institute of Mental Health was directed to establish a new administrative office to determine "national priorities" in the prevention of mental illness and the promotion of mental health, to assist state and local agencies in achieving the national goals, and to develop federal prevention programs.

It is essential to train future social work practitioners for the planning and delivery of mental health services in primary prevention if the profession is to play a significant role in this new mental health revolution. The training material in the sourcebook and the manual is intended to assist social work educators in achieving this goal.

The sourcebook has three sections: (1) Conceptual Framework for Social Work in Primary Prevention; (2) Primary Prevention in the Social Work Curriculum; and (3) Annotated Bibliography in Primary Prevention. Part 1 consists of two articles addressing themselves to the theoretical dimensions of primary prevention and the relationship these dimensions have to social work education and practice. Part 2 consists of five articles describing preventive content that can be integrated into different parts of the social work educational curriculum—practice methods, social policy, research, and field instruction. Although participants in the project recognized that content on life span development has enormous preventive potential, circumstances limited the availability of papers on this subject.[4] Part 3 is an annotation of the major interdisciplinary literature in primary prevention with particular emphasis on concepts and methods that have utility for curriculum development in primary prevention for social work.

Acknowledgments

The making of a book requires the contributions of many hands unknown to the reader. I wish to thank the members of the Project Advisory Committee, who provided ideas, stimulation, and excitement about pioneering in a new area of social work, primary prevention. Some of their written material are part of this book. These papers were originally presented at the project-sponsored national conference, "Primary Prevention in Social Work Education: Implications for the Mental Health Curriculum," held in Louisville, Kentucky, October 21-23, 1979, and at the 1979 and 1980 Annual Program Meetings of the Council on Social Work Education. In addition, the committee is represented by syllabi from courses they teach and by material from preventive programs they work with. The members of the committee were Martin Bloom, Virginia Commonwealth University, Chairperson; Mario Caceres, Hahnemann Community Mental Health/Mental Retardation Center; Philip Cooke, University of North Carolina; June Dunn, Portland State University; Marvin Feit, University of Tennessee, Memphis Branch; Oscar Kurren, University of Hawaii; Lambert Maguire, University of Pittsburgh; Robert Porter, West Virginia University; Helen Reinherz, Simmons College; Robert Santos, Erie County and Ottawa County Mental Health and Mental Retardation Board; and Diana Tendler, Hunter College of the City University of New York.

I thank especially Carl A. Scott, Associate Executive Director, Council on Social Work Education, for his ongoing support during the life of the project, and Samuel O. Miller, who served as the Council's Director of Educational Services during the second year of the project.

The Council on Social Work Education gratefully acknowledges the support of the Social Work Education Branch of the National Institute of Mental Health for the grant (NIMH IT31-MH-15447) which made the Project on Prevention in Social Work Education and this volume possible.

NOTES

1. Milton Wittman, "Analysis of the Seminar on Public Health Concepts for Social Work Education," in *Public Health Concepts in Social Work Education,* Proceedings of a seminar held at Princeton University, Princeton, N.J., 1962 (New York: Council on Social Work Education, 1962), p. 258.

2. Mary Gay Harm, ed., *A Report of the Community Mental Health Practice--Education Project* (New York: Council on Social Work Education, 1978), p. 98.

3. Allen Rubin, *Community Mental Health in the Social Work Curriculum* (New York: Council on Social Work Education, 1979), p. 49.

4. Martin Bloom, *Life Span Development: Bases for Preventive and Interventive Helping* (New York: Macmillan, 1980).

CONTRIBUTORS

SALVATORE AMBROSINO
Executive Director
Family Service Association
of Nassau County
Hempstead, New York

MARTIN BLOOM
Professor
School of Social Work Academic Center
Virginia Commonwealth University
Richmond, Virginia

RISHA LEVINSON
Associate Professor
School of Social Work
Adelphi University
Garden City, New York

LAMBERT MAGUIRE
Assistant Professor
School of Social Work
University of Pittsburgh
Pittsburgh, Pennsylvania

KAREN METZGER
Grant Associate
Services to Families & Children
School of Social Work
Hunter College of the City University
of New York
New York, New York

MILTON NOBEL
Director
Project on Prevention in Social Work
Education
Council on Social Work Education
New York, New York

BARRY M. PANZER
Doctoral Candidate
School of Social Work
Columbia University
New York, New York

ROBERT A. PORTER
Professor
School of Social Work
West Virginia University
Morgantown, West Virginia

HELEN REINHERZ
Professor
School of Social Work
Simmons College
Boston, Massachusetts

DIANA TENDLER
Associate Professor
School of Social Work
Hunter College of the City University
of New York
New York, New York

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PART 1

CONCEPTUAL FRAMEWORK FOR SOCIAL WORK IN PRIMARY PREVENTION

INTRODUCTION

In this section, two articles examine the theoretical foundations of primary prevention and the relationship these theoretical considerations have to social work education and practice. Martin Bloom and Robert A. Porter, the authors of these articles, are both teachers of primary prevention and developers of social work educational programs in primary prevention. Their articles confront the confusion about primary prevention, which is frequently noted by social work educators and practitioners, by isolating the strategy's dimensions. Their clarifications suggest a framework for preventive social work education and practice.

Bloom tackles the confusions surrounding the definition of primary prevention by analyzing the interdisciplinary literature on the subject. He identifies common themes and suggests a working definition for social concerns. Bloom's paper was initially presented at a session sponsored by the Project on Prevention in Social Work Education and held at the 1979 Annual Program Meeting of the Council on Social Work Education.

Porter undertakes the task of "demystifying primary prevention" by (1) exploring the foundation of primary prevention in the socialization process of the conceptualizer, (2) providing conceptual parameters from the social sciences, and (3) outlining the major dimensions from which preventive strategies may evolve. Porter's paper was originally presented at the Council on Social Work Education's conference on Primary Prevention in Social Work Education: Implications for Mental Health Curriculum, Louisville, Kentucky, October 21-23, 1978; the conference was organized under the auspices of the Project on Prevention in Social Work Education.

1

A WORKING DEFINITION OF PRIMARY PREVENTION RELATED TO SOCIAL CONCERNS

MARTIN BLOOM

Primary prevention has recently been heralded as the fourth revolution in society's approach to mental illness.[1] However, a brief review of the literature reveals such a diversity of meanings of "primary prevention" that it suggests the need for a common working definition, lest people jump on a misconceived bandwagon that rides off in all directions. This paper is an interpretive content analysis of two dozen representative definitions of primary prevention from the 1960s to the present, stemming from an interdisciplinary literature. I identify some common themes emerging from this literature review as well as some variations that I predict will take on increasing importance in time. The result is a working definition, not a final statement. Each generation of helping professionals must renew its own meaning of the key concepts that give direction and energy to its efforts.

DIMENSION I. MODELS OF CAUSATION

A. DISEASE-MEDICAL MODEL

Preventive social work stems from many sources, from environmental engineering,[2] medicine,[3] education,[4] and the psychosocial sciences,[5] among others. But it is the disease-medical model in particular that seems to stimulate the greatest definitional effort—either to support it or oppose it. The great bacteriologists (Pasteur, Koch, among others) gave rise to a general conception of *disease* as passing through relatively definite stages—a specific organism causing specific pathologic changes that have characteristic signs (detectable by instruments) and symptoms (directly observable by the victim). Based on this conception of disease, a special social structure emerges in which the victim (now labeled the "patient") is to be treated by a medical expert (the physician or those under his or her direction) in a one-to-one relationship usually within an institution controlled by medical administrators. This composite disease-medical model has been used as a productive orientation for many acute physical illnesses, but many writers have pointed out its limitations for chronic conditions and those related to psychosocial behaviors which apparently derive from multiple sources where no clear-cut etiology is known and where many types of helping in a diversity of organization forms may be useful.[6] With its emphasis on reacting to the underlying causes of illness, the

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disease-medical model gives less attention to current manifestations of effective functioning to achieve high levels of health or self-actualization.

B. THE PUBLIC HEALTH MODEL

The public health variation of the disease-medical model pushed the boundaries both of possible causal factors (to include the physical, biological, and social environments) and the types of organizational arrangements through which helping efforts might be delivered. The impact of this model has been enormous, both in terms of human lives affected and economic considerations. But its major victories soon become commonplace and get consigned to bureaucratic oblivion.[7]

C. LEARNING MODELS

A very different approach to human behavior emphasizes the learning process by which one becomes a person, particularly a mentally and socially effective individual. One variation of this model involves labeling—when a person's behavior deviates from a social-cultural standard sufficiently to justify a sanction, such as isolating that person in a mental institution, as a way of solving a social problem.[8] Other variations emphasize the learning of specific behavioral skills that help the person resist stressors in everyday life, such as providing anticipatory coping experiences with small stresses that may inure the recipient to subsequent large stresses.[9]

D. SOCIAL SYSTEMS MODELS

I would like to offer a compromise on this heated debate regarding models. A general systems model conceptualizes various subsystems as interacting to produce a given event. These subsystems might include the cultural, social, economic, legal and psychological variables (from the learning models) as well as genetic or biological ones (from the disease model). The essential task becomes an empirical one, determining which ingredients are causal and what organizational efforts are most effective in their control. This solution is more nearly compatible with social work education and would encourage interdisciplinary efforts that preventive problems tend to require.

DIMENSION II. THE TIME DIMENSION

Theorists have taken an amazing variety of positions on the time perspective in primary prevention. For most of them, prevention refers to actions taken before a problem has occurred. But upon analysis, it isn't as simple as saying "before a problem has occurred" because in some social problems, the apparently harmful elements have been in existence prior to any specific person's lifetime. It may never be possible to take preventive efforts before a given individual is exposed to poverty, minority status, and inferior social service institutions. Does this mean primary prevention is impossible? I think not. Consider the various meanings attached to the word "before."

A. 'LONG BEFORE'

Some writers use "before" in the sense of "long before"—taking general actions on behalf of whole populations, such as setting up public education or nutritional supports, before specific persons come to need them.[10] However,

these programs have their own goals that do not necessarily give as much emphasis to prevention of social problems as might be desired. Another variation, perhaps of greater use to preventive social work, involves using normative data that predicts what groups of persons are at high risk to have a problem based on their similarity to those who have already contracted that difficulty.

B. 'SHORTLY BEFORE'

Other writers use the term "before" in the sense of "shortly before," as in the crisis situation when some problematic event has occurred (perhaps to someone close) which may be predicted to have severe impact on the target person unless that person undergoes preventive services.[11] This is very close to treatment of a known problem. Perhaps it is possible to learn how to help persons currently in states of crisis to develop methods of providing anticipatory skills—before a given crisis befalls a specific individual.[12]

C. 'SHORTLY AFTER'

Cowen suggests redefining the public health trilogy of primary, secondary, and tertiary prevention so that what are now primary and *early secondary* efforts would constitute primary prevention.[13] I interpret Cowen to be referring to our relative ignorance in predicting social-psychological malfunctioning before it appears, so that by spotting early manifestations of problems we can take actions that prevent more serious ones later. Taking this reasoning one step further, other writers appear to be saying that secondary prevention is the only real form of primary prevention, that it is only after a problem has emerged that we are able to prevent further episodes of the same problem.[14]

D. 'BEFORE A CRITICAL CONFIGURATION OF EVENTS EMERGES'

Rapoport noted that when everything becomes primary prevention, that is, when anything can be aided so that it doesn't become worse, then primary prevention has no meaning.[15] This sentiment is echoed by many contemporary writers who urge a cleansing of the language and a return to "prevention," "treatment," and "rehabiliation." I suggest another element to clarify this time dimension by recognizing that social problems usually occur through configurations of events. For example, we know some neutral events can become problematic in combination with other neutral events, such as when infants become mobile enough to ingest peeling paint chips. Thus, even though the paint chips might have existed "long before" the birth of a given infant, lead poisoning becomes a preventable problem only when other relevant ingredients—a young child, ineffective caretakers, etc.—enter the scene.

E. 'LONG-TERM PERSPECTIVE'

One more note on the time dimension. Kelly, Snowden, and Munoz make an important point in their definition that prevention is long-term, not only in the efforts prior to the would-be problem but also in the continuity of preventive efforts that promote and support the goals of the program.[16] There is empirical evidence for the merit in this observation, such as in the massive social experiment in early compensatory education that needed follow-through to sustain its educational impact.[17] Prevention has an intergenerational dimension, as when the nutritional status of the mother influences the health and educational attainments of the offspring. Kahn's discussion of social

utilities has much the same flavor, especially where promotive and supportive institutions are not for the poor alone, but are available to all as part of the human condition.[18]

Dimension III. Toward Whom Is Prevention Directed?

Theorists tend to distribute themselves along an implied continuum of preventive foci. Some consider the *individual* as the proper recipient of preventive efforts.[19] For example, Poser suggests teaching individuals how to handle fears anticipatorily;[20] Ellis' School for Living teaches its pupils how to deal with irrational beliefs when rough spots appear during the learning of their three Rs.[21]

Other writers consider the *collective* end of the continuum, as when Okin reminds us of the common belief that preventive efforts require extensive, perhaps revolutionary, modification of the entire social fabric.[22] Caplan considers prevention to be a population science, that is, as dealing with populations of persons (at risk or otherwise). He explains that while some individuals may be expected to get sick, the preventive effort is toward the reduction of the incidence of that problem in the total population.[23]

Perhaps the wisest strategy for the present is to deal with the middle range of the continuum between "individuals" and "society." By identifying specific populations at risk in specific places in given communities, we can concentrate preventive activities to attain more effective outcomes—and better cost-benefit ratios. But we cannot obviate some major undesired portion of human behavior and expect that this alone will bring about the desired state of affairs. We need correlated programs that promote the state of affairs we seek.

Dimension IV. Positive and Negative Events; Promotion and Obviation; with Anticipated or Unanticipated Outcomes

This dimension concerns three interrelated ideas. Let me begin by noting that the word "prevention" has a clear obviating sense, to forestall something untoward from coming into existence. But many writers are equally concerned with promoting desired goals,[24] although there is some disagreement on this point.[25] My reading of the situation is that we are at the beginning of conceptualizing growth-promoting experiences, such as "strens" as Hollister [26] or "orthogens" as Poser and King[27] have described them; we are also conducting little research in this area which requires careful exploration.[28] But we cannot obviate some major undesired portion of human behavior and expect that this alone will promote its opposite; we need planned positive programs as well.

Yet we must recognize that although we seek to promote the positive and the desired goals, we may at times discover that we have inadvertently caused unanticipated negative outcomes. A preventive analysis should involve taking into simultaneous account three sets of circumstances: predictions of negative and positive future events, programs to obviate the former and to promote the latter, and contingency plans should the unanticipated occur. By looking for the unanticipated, resulting from either what we promote or obviate, we may be able to produce stronger preventive programs with our initial efforts.

Dimension V. Active or Passive Strategies of Prevention—and the Issue of Values

A dimension of prevention that hasn't received sufficient attention yet concerns the effectiveness of strategies of prevention. For example, is it better to have people buckle their seat belts or to have automatic air bags in case of accidents? The former involves the public *actively* engaged in their own preventive behalf, while the latter acts automatically and the user is a *passive* beneficiary.[29] Hilbert notes that the empirical record strongly supports the greater effectiveness of passive strategies—fluoridation, control over purity of foods and drugs, etc.[30] Next most effective is what Hilbert calls a strategy of having professionals take periodic screenings of people (i.e., annual physical exams) for preventive detection and action. Least effective but most "democratic" is the strategy of informing the public of the risks involved, say with overeating, smoking, drinking, and lack of exercise, and let them take the logical corrective action. Research by Maccoby, Farquhar, Wood, and Alexander suggests that it is possible to increase preventive behavior related to cardiovascular disease at the community level.[31] Yet the surgeon general's warning on cigarette packages seems to have little impact on the horrendous number of new young smokers.

Applied social scientists are generally uncomfortable with measures involving coercion, even when it is undertaken in the name of therapy of persons requiring aid. These ethical questions are magnified when the targets of preventive efforts are currently functioning at an acceptable level. The major ethical dilemma for preventers involves whether to take action now, at considerable public expense, in order to forestall the occurrence of a predicted social problem that would be even more costly to the public. This dilemma is more difficult to resolve when the proposed program involves nonvoluntary participation as the price for optimum results.

In general, I think this dilemma must be faced directly; active and passive strategies should be incorporated into preventive programs. Yet it is a delicate political issue to balance out effectiveness and social sensitivity. The ethical issues are present whether we invite them or not.

Dimension VI. Evaluation as a Necessary Concomitant of Prevention

Several writers address this question directly.[32] Evaluation is not simply an empty exercise in reacting to the pressures of accountability, but it represents a fundamental aspect of preventive work itself. It is necessary, in this future-oriented form of professional helping, to obtain continual information about changing events. Such information will enable workers to modify the preventive efforts during the long-term process in order to approach and to sustain the ultimate goals through successive approximations based on empirical findings.

The implications of this dimension include the pressure to be very specific about our tasks and goals so that operational definitions may be used to test our preventive hypotheses. And we cannot be less specific about the preventive programs and techniques that are designed to attain these goals. Together, these have the effect of promoting a sound scientific approach to preventive practice.

A Working Definition of Primary Prevention for Social Concerns

Summarizing the themes and variations described above, I would like to offer these dimensions of a definition: primary prevention regarding social concerns involves planned actions

1. In selected biological-psychosocial-physical systems that are presumed to be causally linked to target events,
2. On a time dimension before some predicted untoward event (or some desired goal) has occurred, as well as sufficiently long afterwards to sustain effective functioning,
3. Directed toward reducing the incidence of the problem in a specific population of persons at risk (or to increase the incidence of a desired states of affairs in a specific population of persons with potential),
4. Such that the activities could obviate the negative events—personal weaknesses, environmental stresses or limitations—and promote the positive events—personal competences and environmental supports,
5. Using passive as well as active strategies as they seem appropriate, feasible, and ethical,
6. With concomitant evaluation of the progress and outcome of such preventive efforts.

Notes

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13. E.L. Cowen, "Demystifying Primary Prevention," in Forgays, *op. cit.*

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CONCEPTUAL PARAMETERS OF PRIMARY PREVENTION

ROBERT A. PORTER

Conceptual approaches to primary prevention have appeared in the professional literature with increasing frequency during the past decade. This presentation is neither a systematic survey of that literature nor a description of actual programs. It is rather a purposive sampling designed to describe the manner in which these conceptualizations vary along major parameters. I have not restricted the examination to fully developed models or concepts explicitly alleged as preventive. I have instead felt free to include others that offer considerable potential for preventive efforts. Although my focus has largely been restricted to the field of mental health, I have also reached into other substantive areas for content pertinent to the concerns of the social work profession.

The analytical schema used in organizing this presentation derives largely from research methodology. It thus lends itself not only to the development of curriculums for training programs in primary prevention, but equally to the construction of practice models for fieldwork. I hope that this approach helps both to demystify primary prevention by suggesting the relevance of existing knowledge to the concerns of practice and to stimulate an expansion of imaginative experimental efforts in the field.

Preliminary Considerations

THE PROCESS OF CONCEPTUALIZATION AND ITS CONSEQUENCES

A number of considerations have guided the development of the analytical schema used here. Chief among these are the process of conceptualization itself and the different consequences that flow from alternative conceptualizations of a phenomenon. Problems do not enjoy an independent existence in the objective world, but arise in response to our perception of a situation as a problem.[1] The manner in which the problem is perceived is governed largely by the conceptual apparatus of the beholder, and that in turn is significantly influenced by the socialization and social context.[2] We superimpose on the external world a cognitive map that guides us in our relationship to it. This social construction of reality is not only existentially anchored, but is literally in the eyes of the beholder.[3] The human condition would lose much of its fascinating richness and variety were this not so.

This epistemologically complex circumstance has interesting consequences for those concerned with intervention in the human condition with the hope of improving it. Conceptualizations of any given phenomenon may be broad and comprehensive or narrow and partial. The difference is determined largely by the degree to which the phenomenon is perceived as independent of or interactive with contiguous or larger systems. Since problems are solved within the same conceptual framework in which they are defined, narrow conceptualizations—born largely of contemporary pressures for specialization—often offer a poor fit to reality and lead to less than optimal results in interventive efforts.

Many who have conceived and implemented programs of primary prevention feel that the dominant theories in the field of mental health are too narrowly conceived to spawn effective programs of primary prevention.[4] We attempt to compensate for this widely recognized deficiency through the use of interdisciplinary approaches, yet these efforts are seldom successful because the ideological commitments and vested interests of the contending disciplines tend to preclude real integration. A more promising prospect, if we may profit from the experience of the natural sciences, would be offered by a basic reconceptualization of the phenomenon that would cut across disciplines.[5] Until such reconceptualizations arise, the interstitial disciplines—those which attempt to establish linkages between major bodies of theory, such as social psychology or medical ecology—offer promising leads.[6]

A second major consequence of the conceptualization process is that particular constructions of reality may come to dominate public policy and social programming in a given field because of the superior prestige, power, and vested interests of their advocates rather than because of their superior scientific merit or usefulness in practice. The traditional dominance of the medical model in health policy and programming is a dramatic case in point and is a controversial issue in the health field. That model certainly does not fit well with most concepts of primary prevention, or even with many concepts of community mental health.[7]

THE NATURE OF PRIMARY PREVENTION

The emphasis on consequences in this analysis derives from the philosophy of the early pragmatists—especially that of John Dewey—whose cognitive orientation toward problem-solving offers a particularly fruitful framework for a broad conceptualization of primary prevention. The pragmatists rejected speculative, abstract philosophies and emphasized instead the theory that "the process and the materials of knowledge are determined by practical or purposive considerations."[8] Purposeful thought attempts to control events by anticipating consequences in order to secure those conditions that will best serve human ends. Heavily influenced by the methodology of experimental science, the pragmatists laid stress on the experimental manipulation of present means for the purpose of subsequent control. "An idea is a plan of action, a hypothesis to be tested, an instrument whose function is to guide inquiries to the satisfactory resolution of problematic situations."[9] The truth is "that which works," that which is successful in solving problems. The pragmatists devoted major attention to consequences and their control through intelligence.

These brief reflections on the nature of pragmatism suggest the definition of primary prevention as the anticipation of future consequences of current conditions and the purposeful manipulation of present arrangements to achieve desired ends or to prevent the genesis of undesired ones. Primary prevention thus involves foresight (usually derived from theory), human choice, an activist orientation toward planning and problem solving, and a scientific methodology. This pragmatic concept of primary prevention is generic in that it is applicable to any substantive field of human concern.

Dewey rejected the individualistic tradition that characterized much of the philosophy and psychology of his day, as in our own. For him, man is a social animal imbedded in a network of interacting "primary groups." The behavior of the individual is affected by his association with others.

> *Association in the sense of connection and combination is the "law" of everything known to exist. Singular things act, but they act together. Nothing has been discovered which acts in entire isolation. The action of everything is along with the action of other things. The "along with" is of such a kind that the behavior of each is modified by its connection with others.*[10]

Dewey reflects the emerging perspective of the early symbolic interactionists in his contention that

> *individuals still do the thinking, desiring and purposing, but* what *they think of is the consequences of their behavior upon that of others and that of others upon themselves.*[11]

Dewey's psychology is thus inherently social and is conceived within an interactionist perspective at the interpersonal level and within a social systems perspective in its emphasis on the omnipresence of conjoint behaviors. It is a perspective reflected in a number of conceptualizations of primary prevention.

PRIMARY PREVENTION AND MODERN SCIENCE

The last preliminary consideration concerns the relationship between the concept of primary prevention and the procedures of modern science. Modern science attempts to discover the causal framework governing particular phenomena. As it succeeds in doing so, it formulates its discoveries through the construction of symbolic models or replicas of the particular reality. These models or theories set forth a coherent body of propositions that conceptualize the various facets of a phenomenon and posit their relationships to each other. To the extent that these concepts can be made operational, the propositions containing them can be verified through empirical observation, and validation of the theory becomes possible. The ultimate objective of such scientific enterprise is the prediction and control of the environment as a means of enhancing man's adaptation to it.

The concept of primary prevention can be distinguished from the notion of prediction and control of events in the scientific realm only in its emphasis on the *active* utilization of valid knowledge within a time frame which precludes the generation of undesirable consequences that would ensue in the absence of intervention. Even this distinction dissolves in the controls exercised by modern technological society, as in agriculture or industry, to achieve desired out-

comes. Such behavior in the free enterprise world is viewed, not as primary prevention, but as intelligent planning. Perhaps the major utility of the concept of primary prevention is that it draws attention to the fact that we obviously fail, for a variety of economic and political reasons, to adapt much existing knowledge to the ends of prevention in the social realm.

That the concept of primary prevention differs in no significant way from the concerns and procedures of modern science is significant for several reasons. This tie with science demystifies primary prevention and removes it from the esoteric and occult realm of the unknown. It may be true that we have little knowledge of primary prevention, as some contend, but that is true in the same sense in which it can be said that we have achieved only modest knowledge in the social sciences generally. Where valid knowledge exists, it is a matter of social choice whether we exploit that knowledge for the ends of prevention. Certainly there can be no doubt that we have allocated major national resources to the development of a sophisticated remediation technology, disproportionately large in comparison to the modest knowledge base on which it rests, and only a grudging allocation to experimental explorations in the realm of primary prevention. The events of the 1970s and 1980s suggest that it is unlikely that we can reverse this pattern through public exhortation. Preventive action is more likely to occur in response to the exigencies of impending crises, such as run-away inflation in health and other areas, scarcity in the field of energy, or the obsolescence of plants and technologies in industry. Cost containment in the field of health has certainly been one of the major factors contributing to the recent elevation in priorities for preventive programming.[12]

Parameters of Primary Prevention

SUBSTANTIVE FIELD

The first of the key dimensions along which current and emergent conceptualizations of primary prevention vary is the substantive field the conceptualization addresses. Primary prevention has chiefly been associated with the field of public health, and to a lesser extent with the fields of health and mental health. Some reject the concept of mental health because it connotes a medical model (individualism, labeling, remediation, and so on) and substitute alternative conceptual schemes that emphasize the positive aspects of growth, the reinforcement of capacities, and the like. The concept of social role competence and, to a large extent, that of normalization, both of which are discussed later, represent such alternative conceptualizations.

Others, particularly the Marxist contingent in the various social sciences, view the incidence and prevalence of disease in relation to factors of social stratification, economic organization, and the distribution of political power. Certainly it is difficult to imagine effective programs for the prevention of such health problems as malnutrition, infant mortality, black lung, or the psychosomatic ailments associated with occupational stress outside the contexts of these broadly conceived causal models. Indeed, epidemiologists of a Marxist persuasion include alcoholism, drug addiction, and even mental illness within the same causal framework.[13]

There is, however, no logical reason why the concept of primary prevention need be limited to the field of health. According to our earlier definition, all purposive behavior is preventive in that it seeks to achieve certain ends and to avoid others. We don a particular combination of clothes each morning, not only to conform with the exigencies of weather and style, but perhaps to keep a low profile or to elicit attention and admiration or, in the extreme, to avoid social ostracism. In more significant behavior, we build dams to prevent flooding and manipulate monetary and fiscal policies to even out the business cycle and to prevent recession. All purposive or preventive behavior necessarily involves planning, however rudimentary, in that it identifies and organizes current means to achieve predetermined ends. Most of our daily lives involve such behaviors.

This generic and ubiquitous nature of preventive behavior has prompted some mental health professionals to suggest that other disciplines may be more competent to design programs of prevention in mental health than mental health professionals.[14] That is because health and mental health are perceived by many, not merely as the absence of physical and mental illness, but as dynamic personal attributes intrinsically reflecting an equitable and viable social, economic, and political environment.[15]

The imperatives of the modern knowledge-building enterprise, which exert pressures for the division of labor and the specialization of knowledge, compel us to separate out the components of experience for closer scrutiny and study. These components or facets of experience thus become abstractions, severed from their larger moorings. The psychological self is an abstraction. The cognitive, self-conscious self is an abstraction. The individual, as Dewey argues, is an abstraction.[16] The environment is a social and cultural construct that assumes significance only when defined in behaviorally meaningful terms.[17] In isolating these components of experience for observation and study, we run the grave risk of reifying them as separate, independent, encapsulated systems.

The concept of mental health is an abstraction which social workers in mental health, like members of other disciplines, are prone to reify and thus to distort. If we find Dewey's philosophy credible and if we accept the major propositions of modern systems theorists, then we will view the mental health facet of experience as a component that interacts with all other components. Then we can advance the proposition that intervention in any of these various components of experience, singly or in combination—and not just directly in the psychological component, as in clinical practice—can have an effect on mental health outcome. This proposition implicitly or explicitly undergirds many of the conceptual approaches to primary prevention in mental health. Disciplinary boundaries and arenas of practice thus become blurred.

THEORETICAL ORIENTATION

A second dimension along which concepts of primary prevention vary is that of theoretical orientation. Although from perspective defined thus far any theoretical orientation that is sufficiently developed to have operational concepts and empirically testable propositions is potentially adaptable to the ends of prevention, certain theoretical orientations and methodological strategies tend to predominate in the literature of prevention in mental health. Their conceptual and

theoretical development, their validity, their scope, and their operationalization exhibit varying degrees of sophistication. Some of the more prominent of these bear brief mention.

Epidemiology is more a methodology or strategy for knowledge development in the field of health than a substantive theory. It is the foundation science of the remarkably successful public health model and has been adapted to the study of the incidence and prevalence of mental illness and factors related to its distribution.[18] Unfortunately, it has not yet achieved demonstrable success as a preventive strategy in mental health, perhaps because there is so little agreement as to the nature, origin, and mode of transmission of mental illness. Indeed, the viability of the concept itself is challenged.[19] Contemporary approaches to epidemiology are less inclined to separate the physical and emotional components of health and are broadly conceived to include sociocultural, political, and economic factors in the incidence and prevalence of health problems.[20]

Human ecology, which examines the interaction between man and his environment, social as well as physical, emphasizes the imperatives and constraints of the environment that impinge on the adaptive processes of the organism.[21] Contemporary ecological thought avoids the naivete of an earlier environmental determinism by recognizing man's role in affecting his own destiny.[22] According to the sociocultural approach in ecology "there can be no environment apart from that which is defined into being by social and cultural processes."[23] Human ecology overlaps extensively with systems theory in the concept of the "ecosystem," which posits the principle of interdependence or reciprocity between structure and function.[24]

The fact that the environment tends to affect the nature of the adaptive response has given rise to the field of ecological psychology and to the concepts of behavioral settings and contextual effects.[25] For instance, prisons that are sex segregated (behavioral settings) tend to engender homosexual behavior (contextual effect). Such behavioral consequences tend to flow naturally as a function of the environmental structure. Human ecology thus offers the intriguing prospect of achieving desired ends as a natural consequence of institutional manipulations. By this notion the institutionalized homosexuality among prisoners would be reduced as a natural consequence either of community-based alternatives to incarceration or of a program of conjugal visits. Planning within the context of ecological theory offers a similar prospect of minimizing the use of bureaucracies and professional modes of direct intervention in social interaction.

Social systems theory—perhaps more a taxonomic system or theoretic orientation than a formal theory—cuts across the entire spectrum of the social sciences.[26] It gives greater recognition than ecology to the purposive element in human interaction. Social systems theory provides a conceptual framework within which an integration of knowledge from the several social sciences is attempted. Although it has no inherent implications for primary prevention, it provides a particularly useful analytical and planning framework for preventive programming. Its interdisciplinary scope and its emphases on the interaction of system networks, structures, and processes and on anticipated consequences (the relationship of outputs to inputs) all lend themselves to preventive modes of thought. Perhaps nothing is more characteristic of conceptualizations of primary

prevention than social systems analysis and the examination of contextual influences on social, emotional, and behavioral concerns.[27]

Social psychologies, which focus on interpersonal process, primary relationships, and group influences on individual behaviors,[28] are particularly prominent in concepts of primary prevention. A frequently occurring orientation is that of symbolic interaction. For instance, the concepts of normalization[29] and competence[30] are extensively developed within this theoretical perspective. Symbolic interaction stresses the subjective framework of interpersonal communication.[31] Adaptation is viewed as a response to personal definitions of social contexts. The construction of reality which evolves out of this process, both self-perception and the perception of others, carries a strong self-fulfilling momentum.[32] Preventive strategies within this theoretical context thus place emphasis on the positive aspects of growth, institutional supports to enhance optimal socialization,[33] the avoidance of labeling, and the social integration of marginal groups.

The concept of *stress* provides a framework for the development of preventive strategies although it remains poorly developed, vague, and ambiguous.[34] The concept has an inherent appeal as a plausible factor in the generation of physical, psychological, and behavioral disorders. It is most typically viewed as an intervening factor between the stressors of different social settings and dysfunctional outcomes.

The final theoretical orientation in this selective and illustrative list is that of the *clinical psychologies*. Although developed and largely used in the context of remediation concerns, clinical psychologies are nevertheless adaptable to the ends of prevention. Discussion of two of them will suffice for the purposes of this presentation. Skinner in *Walden II* uses reinforcement theory in designing the social and physical environment of his intentional community.[35] Despite the controversial nature of this utopian scheme, Skinner's strategy clearly satisfies our definitional requirement of a primary prevention effort. By extension, behaviorism can be utilized as a framework for social engineering (the design of systems of inducements, incentives, supports, and constraints) to achieve desired behavioral ends.

The developmental approach to the life cycle, as exemplified in the writings of Erik Erikson,[36] emphasizes the interaction between the individual's potential for growth in each of the varying stages from infancy to old age and the ability of the social organization to support and facilitate mastery of the adaptive tasks in each phase. It thus offers policy and program implications for preventive planning.[37]

THE UNIT OF ANALYSIS OR THE LEVEL OF INTERVENTION

A third dimension along which conceptualizations of primary prevention vary has to do with the unit of analysis or the focus or level of intervention. The enormous prestige of the public health model predisposes theorists toward large-scale interventions in vulnerable or target populations. That is partly because the public health model evolved out of concern with communicable diseases for which containment or prevention necessarily involved large scale approaches. It has much merit, particularly in its economy of scale.

We need not, however, let our admiration for the public health model blind us to the dangers of reasoning by analogy in applying that model to the noncommunicable diseases and to the field of mental health. Such a danger, for instance, is posed by the unwitting preconception that primary prevention is applicable only to large-scale strategies, whereas there is obviously no logical reason why preventive efforts cannot be directed toward smaller units of intervention. Programs of anticipatory guidance in the field of mental health or of preretirement counseling in the field of aging are obviously aimed at individuals. So is the physician's advice to his hypertensive patient to lose weight, quit smoking, and exercise more.

Primary prevention may thus be directed toward individuals; diads, such as the married couple; the family unit; informal groups and natural social networks, such as the neighborhood; formal organizations; identifiable vulnerable populations; whole communities or even whole societies, as in national programs to control poverty; the business cycle; literacy; or general levels of health.

The unit of analysis and the level of intervention cannot always be readily and unambiguously determined. That is largely because of the conceptual difficulty often encountered in distinguishing between individual and group properties; there are also methodological problems involved in measuring those properties.[38]

We may, in any case, use the standard designation of this dimension as ranging from the microcosmic, focusing on the individual and small groups, to macrocosmic, focusing on large-scale interventions affecting behaviors and attributes of large populations. Conceptual approaches to primary prevention in mental health span the entire gamut of this dimension or continuum, although they tend to be weighted toward the microcosmic end, perhaps because of the psychological predelictions of most mental health professionals. Certainly theoretical preferences govern the variance along this conceptual axis.

THE CHOICE OF DEPENDENT VARIABLES

A fourth dimension along which conceptualizations of primary prevention vary centers on the choice of dependent variables as the intended outcome of preventive efforts. The choice strongly parallels the unit of analysis or the level of intervention, but is conceptually distinct from it. The unit of analysis, for instance, may be the individual, but the dependent variable may be a subjective or emotional state, such as self-esteem; a cognitive state, such as rationality or knowledge level; or a behavioral attribute, such as gregariousness. On a more inclusive level, the unit of analysis may be the community, but the dependent variable may be social cohesion, cooperation, or patterns of social discrimination. The choice of a dependent variable is strongly influenced by the theoretical orientation of the conceptualizer, although there is no necessary correspondence. Those of an interdisciplinary orientation, particularly practicing professionals, may focus on a mixed bag of conceptual outcomes. Mental health professionals characteristically posit some form of subjective well-being as the ultimate end of interventive efforts. Thus, dependent variables, such as ego-strength, self-esteem, personal identity, and morale are frequent concerns of mental health professionals. Negatively toned emotional states, such as depression, apathy, alienation, and passivity, are similarly the object of preventive efforts.[39]

Those oriented to the social psychologies focus on the prevention of social processes believed to be inimical to well-being, such as discrimination by race, sex, or age, labeling, or social ostracism.[40] Competence in social role performance, with emphasis on knowledge and interpersonal skills, is a major objective.[41] Those who are more structurally oriented emphasize such dependent variables as social cohesion, social integration, patterns of participation, and group and community decision-making structures.[42]

Those of an interdisciplinary orientation reach into the conceptual domain of other disciplines to focus on such objectives as poverty and its many associated social manifestations, the distribution of political power, and others.[43]

The analysis of dependent variables and their measurement in the context of primary prevention pose a different order of problem from that encountered in remediation. In the latter, the identification of the dependent variable is facilitated by the patient's/client's chief complaint. He wants relief from his arthritis, his anxiety, or his poverty. If a good theory is available, the identification of the appropriate independent variable(s) is fairly straightforward, and intervention may be efficient and effective. In the absence of a good theory, however, the clinician's retrospective exploration for plausible independent variables leaves him vulnerable to all the hazards of ex post facto analysis.[44] The search for the appropriate independent variable thus becomes a problem, and treatment efforts become tentative.

Programs of primary prevention, however, are prospective and begin with the manipulation of independent variables. Specific dependent variables may be hypothesized as the desired—though not necessarily the most significant—outcomes. However, the manipulation of any independent variable may have, not a single effect, but multiple as well as unanticipated effects. The dependent variable we measure may reflect only tangentially the real substantive consequence of the intervention. The problem, thus, is just the reverse of that confronting the clinician: analysis of dependent variables may be problematic.

This point is illustrated by a recent report of the phenomenal success of Japanese labor-management relations. Labor department statistics indicate that, since the early 60's, Japanese workers have increased their output by better than three times the annual rate for American workers.[45] This dramatic result has been brought about by a substantial change in labor-management relations in Japanese industry and has attracted the attention and envy of American industrialists, some of whom are emulating the Japanese model with success.

The Japanese have replaced the adversary relationship characteristic of labor-management relations in America with the concept of the corporate community in which workers participate in management decisions. The social distance between management and labor is reduced through the abolition of the traditional hierarchial managerial structure and its replacement with a more egalitarian relationship. Separate dining facilities and parking lots for executives have been eliminated. So have time clocks. Long-term employment is virtually guaranteed. Teamwork often replaces the traditional assembly line. Efforts are made to instill a sense of corporate identity and social purpose. Special events are sponsored to encourage the involvement of workers' families.

For management, the net effect of this fairly far-reaching change in the manner

in which people relate to each other in their workplace has been, not merely a substantial increase in productivity, but a 50 percent reduction in absenteeism, a five-fold reduction in personnel turnover, a significant increase in profits, enhanced job security, and a strong sense of company loyalty and cohesion among factory workers. Japan in consequence has established a favorable international balance of trade and has emerged as a major industrial leader in the world.

For mental health professionals—had they been observing this social experiment—the outcome of this same innovation would most probably have been observed and interpreted in the context of a different set of dependent variables: increases in the self-esteem of workers, in the sense of control over their lives, and in morale, and reductions in alienation, anxiety, physical and emotional complaints, and other negative indications.

A matrix of these and other readily conceivable dependent variables would no doubt yield significant correlation coefficients for all cross tabulations. What then is the real substantive significance of the intervention? What variables shall we choose to best represent the outcome? The obvious answer is that the choice of dependent variables and their interpretation depend on the perspective or vested interests of the observer. Since any phenomenon can be conceptualized in alternative ways, no standard answer is possible. Thus outcome measures chosen to reflect program effectiveness often post questions of inherent relatedness and substantive significance.

THE CHOICE OF INDEPENDENT VARIABLES

The fifth dimension among the axes of variance used to examine conceptual approaches to primary prevention addresses differences in the independent variables that are manipulated to achieve desired ends. Different conceptual approaches to primary prevention are more readily distinguished by their choice of independent rather than dependent variables largely because of the greater overlap among dependent variables. Despite that fact, the conceptual and operational development of independent variables is far less extensive than that for dependent variables.

A further problem is that there is frequent confusion between independent variables manipulated and the technology or mode of practice utilized to achieve the manipulation. This common characteristic of impact studies in program evaluation tends to obstruct theory development. Experimental evaluations of program innovations, for instance, typically concentrate on the comparison of treatment and control groups in terms of significant differences in outcome measures. This less sophisticated development of independent variables is only partially accounted for by administrative and ethical constraints on the manipulation of the human condition. The pressures of public accountability seem to place major stress on outcome measures when, in fact, greater stress on creativity in the conceptualization and manipulation of independent variables may bear far greater fruit.

We might classify independent variables by the disciplines with which they are most typically associated, but a less complex scheme adequately suits the purpose: the simple dichotomy of endogenous and exogenous independent variables, those which emanate from within the biopsychic apparatus and those which emanate from the physical and social environment. Preventive programs address both types of independent variables.

Independent variables that are endogenous consist of cognitive, emotional, and behavioral structures and processes in the psychological realm and of biochemical structures and processes in the physical realm. The classical instance of psychoanalysis involves the manipulation of the relationships between id, ego, and superego. Among preventive programs that address endogenous variables are parent effectiveness training, assertiveness training, competency training generally, anticipatory guidance, infant stimulation, and many types of encounter groups. Educational efforts of this sort attempt to build in adaptive mechanisms in anticipation of future role demands. Yoga and meditation exercises offer preventive potential especially through the control of physiological processes.

The category of exogenous independent variables, which are the ones typically associated with primary prevention, opens up the entire scope of the social sciences. One means of rendering the entire environmental context of behavior manageable is to subsume it under one of the previously described umbrella concepts such as human ecology, systems theory, and epidemiology. Although each of these disciplines has its own dintinguishing conceptual features, they overlap in many respects. In terms of independent variables, all these approaches focus on the structures and processes of community life, all address collectivities, and all view human action as a function of the interplay of systems, that is, in Gestalt terms.

Among commonly identified independent variables of an exogenous nature are cultural, economic, political, social, and physical factors affecting the distribution of populations and resources, the distributional patterns themselves, and the structure and processes of interpersonal interaction in both formal and informal contexts. Some common independent variables are population size, density, and geography as they affect human movement and interaction;[46] policies, decision-making structures, and incentives in formally organized groups;[47] and belief systems and factors of social class as they affect informal groups.[48] Despite the common features among these approaches, they vary in their methodologies and implications for modes of intervention, some of which will be elaborated in a discussion of the final dimension presented after a brief note on intervening variables.

INTERVENING VARIABLES

Public skepticism regarding the prospect of preventive programming in mental health springs in part from the obvious fact that we do not as yet have certain knowledge that would enable us to achieve such ambitious goals as the prevention of mental illness, alcoholism, drug abuse, and other social maladies. We may succeed in helping a decompensated schizophrenic suppress hallucinations and restructure behavior, but there is as yet no prospect of cure. We may also succeed in drying out the alcoholic and support him or her through long periods of sobriety, but again there is no cure. Rehabilitation programs in crime and delinquency are notoriously unsuccessful. We may help the heroin addict shift to the less socially objectionable drug of methadone, but it is for many a dubious gain. Such obervations do not reflect any lack of sympathy for the complexities of treatment efforts.

However, contemporary programs of primary prevention in mental health cannot approach these complex human conditions directly. Rather they are aimed at what may plausibly be assumed to be intervening factors in the causal chain leading to more severe pathology, factors such as those enumerated in the section on dependent variables. Knowledge of these factors is more adequate for prevention. Im-

provement in social conditions, interpersonal relations, and subjective states is a worthy end in itself, even if the assumption linking these intervening conditions with more severe pathology should prove to be incorrect.[49]

Pending the breakthrough to new knowledge in these complex areas, we might do well to regard such human conditions for what, in fact, they currently are—problems in social management, if not problems requiring reconceptualization. The social management approach at least permits us to break out of the current limited options of either an illusory treatment or institutionalization and into a wide array of alternative programming, including mainstreaming and community-based support systems, which are more compatible with preventive strategies.

THE TECHNOLOGY OF INTERVENTION

The final dimension along which we might describe variations in the conceptualization of primary prevention programs centers on the technology of intervention. By what means, strategies, techniques or modes of practice are desired ends achieved and undesired ones averted? What technology is used to manipulate independent variables?

Strategies and technologies of intervention obviously parallel the level of intervention, ranging from microcosmic to macrocosmic. All standard modes of practice ranging from interventive strategies with individuals, small groups, and families to strategies for working with formal organizations and communities are reflected in programs of primary prevention. Preventive planning, changes in the policies of formal organizations, community organization and social action, and community development all have their advocates. Many of these strategies are also reflected in large-scale social movements, which are obviously preventive in their intent and consequences.[50] Among these are the civil rights movement, women's liberation, gay liberation, the consumer movement, and many others. No further discussion is warranted in regard to preventive strategies employed at the "micro" level, as a number of these have already been alluded to.

In its current state of development, the field of primary prevention is characterized by a number of concepts and strategies guiding the technologies of intervention. Among these are the concepts of self-help, mutual aid, and natural helping networks; social role competence, normalization, and social and community support systems; and community development, human ecology, and epidemiology.[51] All are imbedded in some form of larger conceptual framework representing varying degrees of theoretical sophistication.

Permeating the newer modes of practice is a theme of discontent, which is usually explicit, with the traditional perspectives and interventive strategies that characterize the prevailing organization and delivery of social services. Although the parameters of this discontent are well known, since they have been highly visible during the last decade, they bear brief enumeration, since the current complexion in the emerging field of primary prevention may be interpreted in part as a dialectical response to this discontent.

Chief among these complaints are the middle-class bias of the social services, the fragmentation of planning and programming, the social distance between professional and client, the disutilities of bureaucratic structures, the labeling

tradition, the uncertain effectiveness of many services, the dominance of the medical model, the phenomenon of blaming the victim, the client dependence encouraged by all professionals, and the services strategy itself.[52]

Each of the newer concepts or technologies listed here will be described briefly. The self-help phenomenon cuts across the entire range of discontents with service programs by establishing alternatives to them. Although many self-help activities are devoted to what has been dubbed "peer oriented group psychotherapy,"[53] such as Alcoholics Anonymous and Recovery, Inc., the larger self-help movement, centered in such activities as neighborhood improvement, the development of alternative services, and the like is viewed as preventive.[54] Some view it, after the manner of Schumaker's *Small is Beautiful,*[55] as a rebellion against corporate bigness.[56] Self-help is seen as fostering one's sense of autonomy, resourcefulness, and self-direction. In the context of the collective enterprise, it provides identity and status and builds group cohesion. The designation "self-help" is something of a misnomer in that virtually all widely publicized self-help activity takes place within the reciprocal reinforcement of group activity.

The concept of mutual aid within natural helping networks, such as in the family or extended family and among friends and neighbors, dramatizes the informal reciprocities that give cohesion to community life and are a much overlooked resource in the solution of personal problems.[57] Maroney particularly emphasizes the family as a natural caring agent, much neglected and even undermined by public social policy, which is typically directed toward individuals.[58]

The idea of the social support system, as extensively developed by Caplan[59] and as extensively applied by the National Institute of Mental Health to the national program of deinstitutionalization of the mentally ill,[60] emphasizes the coordination and integration of formal communi ty services and informal helping networks in supplying basic human needs.

Labeling theory, in its emphasis on psychopathological designations as self-fulfilling prophecies and as socially disintegrating processes,[61] has strongly influenced the development of alternatives to the psychopathological model. Among these alternatives are the concepts of normalization and social role competence.

Wolfensburger's development of the Scandinavian concept of "normalization"[62] emphasizes the restructuring of social systems to achieve preventive ends. This is accomplished through the social redefinition of behaviors to preclude stigmatization and the reintegration of socially extruded groups through "mainstreaming." It is a relatively simplistic idea with an almost unending range of implications for the management of human services.

The concept of competence emphasizes the importance of a "sense of efficacy"[63] in meeting social role expectations for the performance of tasks. It is approached from different theoretical perspectives and focuses on different levels of intervention. Inkeles, from a structural-functional point of view, emphasizes environmental contexts and opportunities as they bear on competent performance. His approach has strong implications for systems planning.[64] Cottrell expands the concept to the level of "community competence," posits the attributes of a competent community, and describes various means, including community development, as strategies for achieving a viable community operation.[65] Conceivably one could

interpose notions of the "competent family," the "competent formal organization," and the like with appropriate strategies to articulate with these ends. The concept of competence is significant for its emphasis on the positive aspects of growth and development, and the nurturing of capacities, coping patterns, and problem-solving skills in meeting the role requirements of daily living.

Human ecology as a framework for manipulating independent variables suggests the possibility of designing systems or behavioral settings so that desired outcomes flow as a natural consequence of the altered conditions. The flouridation of water or of toothpaste to prevent tooth decay exemplifies an ecological concept; so does the lighting of streets to reduce the occurrence of delinquency. Placing free contraceptive devices in food markets in a developing nation achieved significantly greater results in reducing the birth rate than personalized professional distribution.[66] Our earlier illustration of increased productivity in Japanese industry illustrates the natural flow of a wide range of desired consequences in response to a change in labor-management relations. The principle is that of selecting, where our knowledge permits, contextual inputs to achieve desired outputs, or otherwise of experimenting in an exploratory fashion where prudence allows.[67]

Community development warrants brief mention as a strategy for the achievement of mental health ends, if not as a means of basic economic development, largely because it is so seldom mentioned in the mental health literature.[68] The usual stage model for community development consists of professional entry, community needs assessment, organization of a planning structure, priority setting and implementation, and evaluation.[69] It is used effectively as a strategy for identifying and articulating local needs with national, regional, and local resources. In the usual case, professional roles are catalytic so that community autonomy is maximized and the likelihood of program continuity is enhanced when professional involvement ceases. Actual projects undertaken, though of significance in their own right, may be incidental to mental health outcomes, at least as seen by the mental health professional.[70] Among these are an increased sense of community cohesion growing out of the cooperative endeavor, an enhanced sense of mastery, increased self-esteem and the like, and a corresponding decrease in such qualities as apathy, alienation, and depression.[71] The Leightons, in their Sterling County studies, viewed community development as a viable strategy for counteracting the forces of "sociocultural disintegration," as they conceive them.[72]

Contemporary approaches to epidemiology provide a fruitful framework for the planning and management of community health programs and services.[73] It is an orientation that lends itself to a closer working relationship between public health officials and mental health professionals concerned with primary prevention.

Conclusion

The considerable variance exhibited along each of the several dimensions characterizing conceptualizations of primary prevention provides a wide range of options in the orchestration and development of training programs in this area. The perspective adumbrated in this article views primary prevention essentially as a problem-solving strategy that shifts practice from a crisis or remediation

model to a controlled procedure for achieving preferred outcomes. The usual curriculum components of policy, theory, research, and practice are reflected in this as in other models of professional intervention. The schema used for the organization of this presentation could be used with a fair degree of success in describing the emphases of the curricula now used in many schools of social work. Hence, given a commitment to prevention, the inauguration of training programs in this area should not, in the ordinary case, involve major dislocations in existing curriculum designs. A greater problem perhaps would be to institute appropriate field models in host agencies to coordinate with classroom training.

Primary prevention, like any other form of effective problem-solving, requires creative imagination and a conceptual clarity that can only be achieved through the explicit formulation of practice models. Each of the dimensions of the organizing schema presented here—substantive area; theoretical orientation; level of intervention; dependent, independent and intervening variables; and strategy and technology of practice—poses issues to be resolved or choices to be made in the construction of practice models. It is only through such a procedure that theory and practice can be integrated, that validity and effectiveness can be empirically ascertained, and that a foundation can be laid for cumulative knowledge building.

The demystification of primary prevention is important, not only as an end in itself, but more particularly as a means of overcoming the resistance of both policymakers and practitioners in allocating attention and resources to it. The propositions of valid knowledge may be used to guide either remediation or preventive efforts, although the technologies of intervention would usually be different.

For example, the proposition that the phobic reaction is a response to an antecedent psychic trauma gives direction to both therapeutic and preventive efforts. Therapeutic efforts might be directed toward desensitization to the traumatic event or the symbolic stimulus; preventive efforts might be directed toward patterns of socialization that avoid overstimulation. To draw an illustration from economics, if inflation is caused by an oversupply of money in circulation, the situation may be remedied through techniques such as increasing taxes and interest rates or reducing public spending. In a period of economic stability appropriate control of these same factors may be used to prevent an overly heated economy. If this strategy seems no longer to work well, it may be, not that the theory is wrong, but that the assumption of a free market on which it is based is no longer tenable. In any case, the same knowledge base is used to guide either remediation or preventive efforts. By extension, all scientifically constructed knowledge is potentially exploitable for preventive ends. The contention that we possess more knowledge than we are willing to put to use in the remedy and prevention of social problems is, I believe, defensible. What is more likely to be lacking is the public will and the technology for adapting the knowledge to socially desired ends.

The politics of primary prevention is a reality to be dealt with. It requires an activist, or proactive, planning stance, rather than a reactive one. Most theories brought to bear in this field posit an interdependent or unified social fabric and thus imply the necessity of comprehensive rather than sectoral planning. The mental health component of experience, as Erikson suggests, is

rooted in social organization or, as Dewey suggests, is a social product. Approaches to prevention or remediation that isolate this component of experience from its larger existential roots in the social environment are likely to falter.

Such thoughts, however, evoke the specter of an activist government, elitist bureaucracies, and high taxes, all of which are offensive to the political sensibilities of most Americans, and not without justification. We need, therefore, to develop interventive strategies that minimize these undesirable consequences. Can it be done? The insights offered by human ecology and the self-help movement suggest some possibilities, although we need desperately to explore and develop others. For example, the concept of "sweat equity" has led to productive partnerships between the private sector and the residents of blighted urban areas in the remarkable revitalization, in social as well as physical terms, of many of our urban neighborhoods. Although such projects are obviously rehabilitative from a housing perspective, they may be regarded as preventive from a mental health standpoint. The social interaction engendered by the cooperative participation of primary groups in a common endeavor enhances social cohesion, a sense of autonomy, self-esteem, and similar subjective qualities. The success of preventive efforts depends, not just on the development of valid models of intervention, but equally on the degree to which they can be integrated with the basic political ethos of American life.

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PART 2

PRIMARY PREVENTION IN THE SOCIAL WORK CURRICULUM

INTRODUCTION

The five articles in this section present content on prevention that can be integrated into social work curricula to foster an orientation toward prevention and to develop skills in preventive practice. The articles address such curriculum areas as practice methods, social policy, research, and field instruction. Four of the five articles—all but the article by Diana Tendler and Karen Metzger—were originally presented in workshops at the Council on Social Work Education Conference on Primary Prevention in Social Work Education: Implications for Mental Health Curriculum.

Lambert Maguire reviews the research literature on natural helping networks and self-help groups and evaluates their utility as practice modalities for primary prevention. He emphasizes the role of the professional social worker in facilitating and working with these social support systems.

Risha Levinson presents the concepts of developmental provision and social utilities as orienting schemes for the teaching of preventive programming in social policy courses. She views these concepts as parallel to health promotion approaches that focus on total populations and other approaches that selectively seek the prevention of mental disability through the identification of high-risk populations. Citing the preventive principles of anticipatory guidance and developmental provision, she emphasizes the need to reallocate societal resources and to develop new methods of preventive practice.

Helen Reinherz presents a comprehensive analysis of the major issues in the evaluation of primary prevention programs. She addresses the issues raised by critics of primary prevention and adds to the body of knowledge for prevention advocates. She reviews the research considerations in evaluating preventive efforts and offers exemples of well-developed research programs in primary prevention. She concludes with some recommendations for training social workers to evaluate prevention programs.

Diana Tendler and Karen Metzger address the application of prevention concepts and content to fieldwork instruction. They also suggest a model for mixing primary prevention techniques with the traditional social work services of treatment and rehabilitation. Their article concentrates on the development of a preventive orientation in students and on the teaching of preventive skills. The authors also discuss the possibilities primary prevention offers for bringing social work services to a larger population than could be reached through traditional services.

Salvatore Ambrosino describes primary prevention as part of the services offered by family service agencies. He advocates a program of family life education and family advocacy for prevention and health promotion, but he recognizes the need for counseling for those individuals and families who require additional help. He strongly emphasizes the need to differentiate family life education from counseling services to clients and points out the usefulness of family life education as a modality for reaching such high-risk groups as minorities, youth, the poor, and the aged. He also discusses the implications such a program of integrated services has for social work education.

3

NATURAL HELPING NETWORKS AND SELF-HELP GROUPS

LAMBERT MAGUIRE

In recent years, there has developed a tremendous interest in the use of natural helpers in mental health and the social services. Natural helpers can best be described as lay people in communities who have the natural capacity to be empathic and concerned in providing various forms of advice and support to friends, neighbors, relatives, and co-workers. In many instances, these natural helpers are central figures in neighborhood networks or social support systems. At other times, these individuals help form the nucleus for somewhat more formally structured self-help groups that concern themselves with common problems or issues. In either case, the role of professional social workers with these two natural helping systems is not yet clearly defined.

The report of the task panel on community support systems of the president's Commission on Mental Health emphasized that although community mental health programs and social service programs have made significant gains in their capacities to work with and develop the natural human resources in communities, more needs to be done.[1] The professional or formal system cannot cope with current or anticipated demands, and it is essential that social workers and other mental health professionals use their limited resources for whatever kinds of interventions are most efficient and effective. A growing body of evidence indicates that professional efforts aimed at identifying, developing, and supporting natural helping systems would be the best way to maximize formal or professional resources as well as those of the natural helpers. Collaborative efforts to recognize and develop the resources and capabilities of both the professional service system and the natural helping system produce more effective interventions, particularly in the area of prevention.

NATURAL HELPING NETWORKS

> *Individual's social relations, both personal and intimate ones and impersonal and formal ones, can be thought of as strands in the webs of their "social networks." The networks radiate out from the individual to close associates and then to the complex society beyond. Conversely, society can be thought of as the complex mesh of all these social networks, an intricate latticework.*[2]

Natural helping networks can be conceptualized from two separate perspectives: the general community networks or the personal social network. The function of the general community network is preventive, whereas the personal social network has a treatment as well as a preventive function.

Although the evidence supporting the positive effects of networks is still developing, it is sizeable and diverse. Essentially, two large bodies of research support the network approach. One is the social survey research literature. Nearly twenty years of such surveys show that people who have close support systems or networks of family and friends are not only generally healthier psychologically, but perceive their quality of life as better on a variety of indicators. This was the finding in the Midtown Manhattan survey, in the *Americans View Their Mental Health* study, and, more recently, in the national surveys on *The Quality of American Life.*[3] Although socioeconomic and demographic variables, particularly those of marriage and sex, account for much of the variance in the results, the positive effects of the natural helping networks in prevention are reasonably consistent.

The other area of empirical support for the use of networks comes from a variety of epidemiological studies. The voluminous work of the president's task panel reports points out and supports the finding that people who are connected to others via some personally meaningful support system or network of relatives, friends, and neighbors seem to exhibit fewer overt psychiatric symptoms than those without such supports.[4] Gore has found that the strength of the network or support system of unemployed men seems to account for the significant differences among men in relation to depression, cholesterol levels, and a variety of physical ailments.[5] Nuckolls et al. similarly found that pregnant women who had supportive systems of spouses, friends, and relatives had fewer complications related to pregnancy than those without such support.[6]

The research on stress factors also lends credence to the idea that networks serving as support systems perform a moderating or buffering function for individuals. Cassel has noted that stressful social circumstances have been related to the onset of tuberculosis, schizophrenia, alcoholism, multiple accidents, and suicide rates.[7] He notes that not only does research support this correlation, but that in each of the studies, the victims or "host" subjects tended to be people who maintained a marginal status in society and who were deprived of meaningful social contact. Methodological problems related to defining and measuring the appropriate network and its size, density, range, function, and so forth are considerable, but work by Fischer on assessing and defining personal networks and by Pancoast on general or community natural helping networks should enable future researchers to explore the relationship between individuals and their networks more precisely.[8]

However, it is unnecessary to wait for more evidence before interventions can be developed. There are many examples of work being done with both general and personal helping networks. Perhaps the best known social work efforts with general or community natural helping networks has been the project developed by Collins and Pancoast.[9] In their book, they explain how a natural helping network of day care providers for children worked in Portland, Oregon. It was composed of a network of rather amiable, outgoing, concerned women who cared for children in their homes. These women knew each other and assisted each other, but primarily they provided the stable, loving environment that working parents sought for their

children. Through their sensitive and patient development of relationships with this network of women, Collins and Pancoast found that they could encourage, support, and improve the natural helping network and thus prevent some of the problems and stresses that accompany inadequate care for young children.

Biegel and Naparstek provide another example of professional social workers involving themselves in developing general or community natural helping networks.[10] In their empowerment model, they use a helping network framework that relies on a neighborhood focus, and they concentrate on developing the communications or linkages within neighborhoods between the lay and the professional networks or the service delivery systems. Rather than "parachuting" professional services into communities, they work along with existing community leaders and community institutions, such as churches and neighborhood ethnic organizations. Professionals serve on advisory committees to the community groups. In using such existent informal institutions, they find that, for instance, many ethnic, working-class women avail themselves of support groups sponsored by their church, whereas similar groups sponsored by community mental health centers would not succeed.

Gerald Caplan found not only that natural helping networks exist in communities, but that there are even generalists and specialists central to such networks.[11] Generalists tend to have central positions in communities, such as bartenders, beauticians, and barbers, and have naturally outgoing personalities and empathic capabilities. They listen to people well and provide advice or suggestions on a variety of issues. Specialists tend to be people who have lived through the problem themselves, such as widowhood, alcoholism, or the delivery of a child with a birth defect, and who can provide understanding, support, and advice to neighbors similarly affected.

Although these examples and others by Froland and Pancoast[12] and Garbarino and Stocking[13] demonstrate how social workers can support or use general natural helping networks in communities to prevent problems, other workers use the more personal networks of individuals or families for treatment and prevention. Recent approaches involving personal networks show a great deal of potential in the way social workers can purposefully intervene with the persons most significant to people in need. Attneave, Rueveni, and others have advocated and developed social network intervention, whereby the professionals undertake a leadership role and help gather the extended family and friends of families with problems and guide them through six stages to work through a problem: (1) retribalization, or convening the network, (2) polarization, or recognition of differing or polarized viewpoints of what the problem is, (3) mobilization, or facilitating the discussion of various actions or means of handling the problem, (4) depression, which follows when members recognize that they will not come to any quick or easy solution to the problem, (5) breakthrough, which occurs when the network members begin to agree on approaches and on the belief that a solution can be found, and (6) exhaustion-elation, wherein the members satisfy themselves that some realistic means of alleviating the problem has been met.[14]

Social network intervention is oriented to treatment and rehabilitation. As the public and professionals become more aware of the potential natural helping networks have for preventive functions, funding may develop for the networks. The interest in natural helping networks has thus far grown despite the general lack of financial support. This may be attributed to the great potential for using

these networks as a resource and to the absence of alternatives. It would be unfortunate if this potent force for primary prevention failed to develop.

Self-Help Groups

Silverman distinguishes four types of mutual helping organizations: (1) those interested in fund-raising for a particular common problem, such as the March of Dimes, (2) those developed for the purpose of political action, which, like the women's movement, often involve changing laws or public attitudes, (3) mutual help organizations involved in consumer advocacy, such as the many parent groups involved in busing their own or other children, and (4) the personal help groups, such as Alcoholics Anonymous and La Leche League for Nursing Mothers, which are maintained primarily for the purpose of individual self-help.[15] It is this last type of self-help group that is considered in this section and that along with the natural helping networks described in the previous section, most clearly demonstrates the elusive human qualities of compassion and genuine concern for other human beings that seem to be the strength or core of the "natural" trend in mental health.

Genuiness, empathy, and a positive regard or warmth toward people in need are all qualities that professionals in mental health are encouraged and sometimes even trained to utilize and develop,[16] but professionals with large and varied caseloads seldom maintain these qualities spontaneously over long periods of time. Something more, or at least different, is needed with some clients at some times. Neither the formal, professional mental health system nor the informal, nonspecialized natural helping network can be expected to meet all the needs of all clients.

Another kind of informal or natural system composed of self-help or mutual help groups frequently combines specialized knowledge about specific problems with the empathy, genuiness, and warmth of the natural helping network. People who bond together to help each other with a problem held in common can be mutually helpful. In studies done by Lieberman and Borman to compare self-help groups with professional intervention, the self-helpers were frequently found to be as helpful as their professional counterparts. The authors found that in many cases, the self-help group members had gone to professionals, but had not received the type of help they felt they needed. Furthermore, the understanding and help from family, friends, and neighbors were also lacking because of a dirth of knowledge and sensitivity to the specific or peculiar concerns of these clients. For instance, although family and friends may have been willing to help, it was difficult for them to comprehend the pain and anguish of their friend's alcoholism, obesity, widowhood, or terminal disease. In contrast, self-help groups tend to be sensitive to those feelings.[17]

Borman found that five of the curative factors studied by most social workers in group work courses seem to account for much of the success of these groups: (1) *universality*, or a recognition by these group members that they are not alone and that the others with whom they meet have the same problem, (2) *acceptance*, whereby the other members neither condone nor disapprove of the problem, but accept the person and the problem, (3) *hope*, which is instilled by these groups, especially as members see that the self-help group seems to help others with similar problems or concerns, (4) *altruism*, or feeling better about oneself through the experience of giving help, support, or guidance to others, and (5) *cognitive restructuring*, which sometimes involves a detailed belief system as in Alcoholics

Anonymous, or sometimes simply involves new knowledge imparted to them about the causes and effects of their problem.[18]

Lieberman points out that there is tremendous diversity among such groups and that, although universality is a central issue in women's consciousness raising groups, for Compassionate Friends, a self-help group composed of parents who have suffered the loss of a child, the instillation of hope and ultimate acceptance of the loss are more important.[19]

In Levy's attempt to analyze quantitatively the help-giving activities of self-help groups, he found "that the nine more frequently occuring activities are empathy, mutual affirmation, explanation, sharing, morale building, self-disclosure, positive reinforcement, personal goal setting, and catharsis."[20] He further indicates that although his research cannot assess the effectiveness of these activities, it appears that the groups are providing the members what they want—understanding or empathy, affirmation of their self-worth, advice and feedback or behavioral prescriptions, and positive reinforcement. These are all activities that are supported in professional practice.

Although self-help groups such as Alcoholics Anonymous, Recovery, Mended Hearts, and others are undoubtedly helpful and seemingly fill a void that professionals either cannot or will not fill, it would be unwise to see them as an immediate replacement for professional intervention. Rather self-help groups should be perceived as a preventive force or stabilizing influence; frequently they serve as a complement to treatment as well. In either case, social workers can learn from the success of self-help groups and develop relationships with such groups and support and encourage them.

There are ten practical resources that can be provided to mutual or self-help groups without undermining their natural strength:

1. *Meeting place.* A practical, obvious, but sometimes overlooked necessuty is a location for such groups to meet. Social workers in community agencies, psychiatric clinics, hospitals, or social or family service agencies can provide a conference room or large office for meetings, which frequently occur in the evening when many professional organizations do not use their facilities.
2. *Funds.* The minimal amount of money needed to develop and operate most self-help groups would amaze and perhaps even embarrass many social workers. Lieberman and Borman's studies indicated that it was not unusual to encounter nationally organized self-help groups with dozens of chapters that operated on budgets of well under $100,000 per year.[21] However, the provision of funds to help at least temporarily with mailing, telephone, or coffee expenses can make the difference between such a group's developing or not.
3. *Information.* Professionals frequently have the information that the members of self-help groups lack. Information, or at least leads to obtain needed information, can be provided for everything from welfare, housing, or medical costs to legal services.
4. *Training.* Training can be offered in a variety of directly or indirectly related areas. For example, Mended Hearts, a self-help group composed of heart attack victims, may request a nurse or medic to provide training in cardiopulmonary resuscitation at some of the group's meetings. Training may also be requested by leaders of

self-help groups in how to recruit members, or in another case, how to relate to hostile community residents trying to block the introduction of a halfway house composed of many of the group's members.

5. *Referrals in.* Professionals can help self-help groups by referring clients to them. Whether this is a corollary to the treatment provided by the professional or the sole means of help, such referrals help build and develop these organizations.
6. *Referrals out.* When professionals develop a good rapport with the members of the organization and demonstrate an interest in and sensitivity to their problem, the group often refers some of its members to them. By maintaining open and honest communications, whereby legitimate respective strengths and areas of expertise are identified and recognized, a climate for appropriate cross referrals can be developed that benefit the people in the group and maximize the effectiveness and efficiency of both the professional and the self-help group.
7. *Credibility in the community.* Credibility is important to the viability of self-help groups, and the professional can enhance such a group's credibility by making positive comments about it in dealing, for example, with community leaders or politicians. Permitting the group to publicize, if it wishes, that it works with a professional may help legitimize the group in the eyes of community people, although, ironically, the group's self-sufficiency should be what most impresses outsiders.
8. *Credibility in the professional community.* The mutual ignorance of and animosity between self-help groups and the professional community is only recently beginning to change. Professionals are beginning to probe and research into such groups and see their positive effects, and at the same time, the self-helpers are increasingly "professionalizing" various aspects of their organizations and even utilizing some of the research professionals' to improve their work. Concerned professionals can inform their local professional organizations of the existence of these groups in their area and of the group's positive effects.
9. *Buffer.* There are times, especially in the early stages of a group's development, when it may come under attack. This may be from professionals who see them as incompetent, from neighborhood residents who view them as a nuisance or a source of embarrassment, or from relatives and family members who do not understand why their spouse or siblings prefer the company and help of "strangers" and thus feel a sense of failure. Providing this buffer entails primarily consultation and education to the unfriendly parties.
10. *Social and emotional support.* The professional should be careful not to usurp the position and authority of the leaders of self-help groups or to "save" them when they falter. Yet they should be available to support and encourage the self-help leaders and other members when asked to do so. Respect must be implicit in all interactions with the self-help leaders and members. The professional can help by listening and offering suggestions and help if such help is solicited.

Summary

The resurgence of interest on the part of social workers and others in utilizing the "natural" system of self-help groups and personal and general community networks is a trend to be welcomed. There is a growing body of evidence that networks and support systems provide a buffer against the effects of stress and that people with adequate supports tend to cope more successfully and perceive life as somewhat better than more isolated individuals. Problems stemming from the ignorance of both professionals and the public concerning primary prevention will no doubt diminish as more research is done in the field.

Self-help or mutual help groups are a natural development that have a great deal of potential in both prevention and treatment. Recent research indicates that these groups effectively use some of the same curative factors that professionally developed groups use and that their activities are similar to the interventions or at least to the core qualities which research indicates are related to successful outcomes in treatment by clinical social workers.

These natural approaches in mental help must be further understood and developed by social workers. Working relationships must be developed between this informal system and the formal one. However, social workers should not perceive natural networks or self-help groups as panaceas or as replacements for their own needed services. The consequences of that type of abdication can be disastrous, as was seen in the late 1960s and early 1970s when social workers too often left paraprofessionals to flounder or turned encounter groups over to untrained group leaders. Yet sensitive interactions between the professional and nonprofessional systems, combined with mutual respect and support, can no doubt lead to significant improvements in the field of prevention.

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DEVELOPMENTAL PROVISION: A PREVENTION-ORIENTED CONCEPT IN TEACHING SOCIAL POLICY

RISHA W. LEVINSON

A major contribution of the 1962 Princeton seminar sponsored by the Council on Social Work Education and the U.S. Public Health Service was Kahn's formulation of the concept of developmental provision.[1] Although acknowledging the efficacy of the public health model in the planning and coordination of social work services, Kahn argued that developmental provision goes beyond prevention and should therefore be considered apart from the public health model.

This separateness of provision from prevention was contrary to an earlier formulation by Boehm, who held that the two are not "entirely separable," but occur simultaneously as basic functions of social work.[2] Although Kahn's interpretation of developmental provision agreed with Boehm's focus on "effective allocation of social resources," he disassociated "personal incapacity" and individual inadequacy from the concept of developmental provision. According to Kahn's formulation, social services are to be available as a matter of right and entitlement and not restricted to a reactive response to individual malfunction or personal pathology. According to Kahn, developmental provision is to be regarded as a normal front-line contribution to the shape and form of society and designed to meet an acknowledged need in social living.[3]

The premise of this article is that provision is neither entirely separate from nor totally merged with prevention. It is argued that these are complementary concepts in the sense that provision is a *vehicle* for the promotion of prevention; the goal of prevention can be advanced by a planful and effective provision of resources.

This symbiotic relationship is highlighted in the article's brief overview of the historical involvement of social work in promoting prevention through developmental provision. The article further notes the commonalities and parallels between the two concepts, examining their shared features in a societal context and in relation to promoting health in total and target populations. The final section of the article describes a sequence of social policy courses that was structured around the premise that developmental provision can advance prevention. The concept of developmental prevention was thus used to orient course participants toward prevention.

Definitions and Delineations

Kahn has defined developmental provision as the resources, services, amenities, and universally available public social utilities that are the core of the guaranteed minimum of goods and services that society defines as essential to survival. Kahn uses the terms "developmental provision" and "social provision" synonymously to denote the social-societal implications of provision as a legitimate and essential feature of a modern and mobile society.[4]

This delineation of developmental provision is based on the institutional perspective of social welfare that regards the provision of services as a "normal front-line function of society," available to all citizens as a right and entitlement. This view is in opposition to the residual perspective according to which services are directed to "persons with problems" when other systems breakdown, such as the family, the church, or the school. Thus, problems are viewed as products of personal failings rather than collective needs.[5]

The institutional view of social welfare supports the concept that social services should provide entitlements and benefits and are thus to be regarded as public social utilities whose function is to meet the normal needs of people arising from their situations and roles in a postindustrial society. The social utilities reflect collective provision for common human needs in a changing society, such as services relating to family planning, housing, employment services, day care, family and youth centers, and community programs for the aging. The focus is on communal provision, rather than on individual maladjustment or moralistic judgment.

The purpose of social utilities is to serve the normal needs of the socially healthy at points of stress, crisis, and transition where breakdowns may often be anticipated—for example, at the onset of parenthood, upon entry in schools, and in adolescence, marriage, and old age. In essence, a social utility is a social invention, a resource or facility designed to meet a generally experienced need in social living.

Unlike social utilities, case services are directed toward diagnostic services for individuals with problems who are in need of treatment of help to bring about cures or improvements in personal adjustment. Just as the institutional approach is not totally discontinuous with the residual approach, social utilities cannot exist entirely independently from case services. Developmental provision calls for a balance or mix of resources, but with special attention to the expansion of social utilities and universal access to human services.[6]

The dual goals of developmental provision are (1) the avoidance or reduction of problems, and (2) the enhancement of living. By definition, these are the goals of primary prevention. Although treatment (secondary prevention) and rehabilitation (tertiary prevention) are important in any system for providing resources, the major thrust of developmental provision is toward primary prevention. To avoid confusion and ambiguity of terms, Klein and Goldston suggest that the terms "prevention" and "primary prevention" be used synonymously.[7] For purposes of clarity, these terms are used interchangeably throughout this discussion. However, a brief historical background will further illuminate the duality of provision and prevention and establish a deeper and broader understanding of social

work's use of developmental provision as a means to prevention.

Background

In a sweeping overview of social work's history of interest in prevention, which dates from the preprofessional period through the early 1960s, Kahn traces the preoccupation of notable social reformers of the early nineteenth century. They were involved in social action programs to eradicate or ameliorate the undesirable social and environmental conditions that were viewed as both a consequence and a cause of poverty.[8] At the turn of the century when the social work profession emerged, social work leaders were among the "progressivists" who campaigned to provide "the good life" through environmental controls, legislative regulations, labor organizations, women's suffrage, and other social action programs. Although the emergency legislation of the depression era was more reactive than proactive in meeting the crises of economic disaster and mass unemployment, the landmark legislation of the Social Security Act of 1935 reflected a new era for social provision through social insurance as well as public assistance. However, during the 1940s and 1950s, when social work became more involved in case than cause, the profession's interest in developmental provision became more implicit rather than explicit.

The sixties saw a resurgence of interest in prevention that was generated primarily through federal initiatives. As Wittman observed, "New legislation is the perennial spur to action."[9] Although the goal of prevention was incorporated in the economic opportunity programs designed for the poor and in the comprehensive mental health programs aimed to serve all citizens, the actual implementation of the preventive aspects of these programs was more ideal than real, despite the rhetoric to the contrary. Nevertheless, the interest in prevention gained momentum and helped shape the Title XX legislation of the Social Security Act of 1974, a new milestone in the provision of services for total and target populations. In fact, Title XX represents the most significant legislation to date to promote preventive intervention. The overriding concern for prevention is embodied in four of the five delineated goals of Title XX, which specify targets and strategies for prevention:

1. The prevention of dependency, through economic self-support.
2. The prevention of dependency through self-sufficiency.
3. The prevention of child and adult abuse and exploitation by preserving, rehabilitating, or reuniting families.
4. The prevention of institutionalization by providing community-based care, home-based care, or other forms of less intensive care.[10]

Title XX reflects a developmental provision approach by including universal services as well as income-tested services. Among the universal services mandated "without restriction of income eligibility" are information and referral services, child and adult protective services, and family planning services. These selected universal services represent a potential for expanded social utilities, reflecting what Gilbert refers to as "the drift toward universalism."[11] The mandate for annualreviews, public hearings, and involvement of the private sector through service contracts suggests new opportunities for programs aimed at prevention.

Parallel and Complementary Concepts

To understand provision as a means to achieve the goals of prevention, it is necessary to recognize the parallelism of these concepts and the complementary relationship between the two approaches. Prevention represents a goal for "developmental provision," and provision can also be a means to achieve a desired goal of prevention. The commonalities these concepts share within a broad societal context are based on their mutual interest in health promotion for total and target populations.

HEALTH PROMOTION

Etymologically, both "provision" and "prevention" share common Latin origins. "Provision" stems from the Latin words *pro-videre*, which means "to see beforehand," and "prevention" is derived from the Latin *prae-venier*, which means "to come before." Inherent in both concepts is the idea that both planning and anticipatory programming are antecedents aimed to avoid, avert, or reduce the undesireable event or circumstance. In an extensive overview of the definitions of primary prevention, Bloom cites various authorities who assign different time frames to primary prevention, including "long before," "shortly before," and "shortly after" some predicted untoward event or some desired goal. Bloom concludes that primary prevention occurs before an event and sufficiently long afterwards to sustain effective functioning.[12] "Developmental" also denotes a temporal progression, that is, provision over time in response to changing conditions and shifting needs, which continually require new social inventions for provision.

Health promotion implies the advancement of the positive, the desireable, an improved quality of life. The public health model is traditionally associated with pathology, contagion, and disease, which accords with the residual perspective. Of equal and growing importance, however, is the public health goal of health promotion, a perspective that more closely parallels the institutional view of social welfare. Besides an increased emphasis on programs of personal health care and health maintenance, such as weight control, antismoking, and physical fitness programs, health promotion also includes antipollution and noise abatement campaigns, programs to insure access to health care and social services, and a growing concern for the reduction or resolution of complex social problems.

In setting forth the concept of developmental provision, Kahn specifies that developmental or social provision should not be limited to the control and eradication of pathology, but should deal with "enhancement and betterment" to maximize the goals of socialization and human development. Clearly, the emphasis in social provision is on the health-absence-of-health continuum, rather than the sickness-absence-of-disease continuum.[13]

THE SOCIETAL APPROACH

The developmental provision approach assumes that a responsible society will provide resources and emenities that will be responsive to the changing needs of a postindustrial mobile society.[14] Shrinking budgets, energy shortages, rapid shifts in socioeconomic conditions, and dramatic technological advances have brought about sweeping changes. Demographic shifts in age profiles have emphasized the needs of the growing numbers of the elderly, and changing family patterns have highlighted

the needs of single-parent households. Problems of unemployment and income security remain complex in the face of mounting inflation. In view of these societal shifts and newly emerging patterns, other institutional vehicles need to be invented to perform some of the traditional functions formerly carried out by the family, the neighborhood, the extended family, peer groups, and religious institutions.

Even the personal life cycle, which was at one time regarded as a standard model for planning developmental provision at predetermined checkpoints in the life of the individual, has undergone vast and profound changes. Hirschhorn has observed that the fluidity of contemporary life is a result of social changes related to diverse household compositions and changes in the nature of work and jobs. He concludes that new problems have been generated as a result of "the intersection of developmental problems and social conditions."[15]

The societal perspective articulated by various proponents of primary prevention generally reflects the discipline in which the individual is engaged in, be it medicine, public health, education, or social work. While Hilbert calls for "appropriate environmental action in prevention programs,"[16] Kelly asserts that primary prevention means changing the local conditions of a community or an organization "to improve positive development of persons or reduce negative reactions to stress."[17] Assuming a bolder societal stance toward prevention, Okin declares that "prevention should shape the very foundations of our socioeconomic order through redistribution of income and wealth among classes, and a substantial diversion of resources with social services."[18]

TOTAL AND TARGET POPULATIONS

Developmental provision is concerned not with individual malfunction or personal incapacity, but rather with the allocation of resources in the light of social priorities and recognized service needs for total populations. In essence, developmental provision represents social inventions based on communal needs, collective experiences, and changing roles in modern social life.

Similarly, primary prevention is directed more frequently to total populations rather than to individuals. According to Klein and Goldston, "Primary prevention is concerned about total populations, especially and including groups at high risk; it is less oriented to individuals and to the provision of services on a case-by-case basis." They further pointed out that "individual response to preventive intervention is very difficult to control, let alone prove"; however, "incidence within a population can be measured, and change in incidence can be demonstrated."[19]

It is therefore apparent that programming for prevention entails not only provision for commonly experienced needs of total populations, but also provision for identifiable target groups that require "preventive intervention--for example, a day care program for the visually handicapped, a homemaker program for the elderly, or a public works program for unemployed youth.

PREVENTIVE PROGRAMMING

A preventive program based on developmental provision ultimately depends on the planning and implementation of resources and service programs. These pro-

grams must provide social utilities and case services, focus on general needs as well as specialized needs of population groups, and provide universal benefits as well as income-tested assistance. The program choices will thus depend not only on assessment of need, but also on the delineation of values, preferences and priorities accorded to social provision.

Programming entails a specification of goals in the planning, initiation, and implementation of programs. To assess prevention in social programs, goals need to be defined in measurable terms, lest provision for prevention remain but an idle slogan rather than a working objective in a planfully formulated program.

A prerequisite for developmental provision is that services be both available and accessible. In spite of the proliferation of services, access to appropriate services has remained a serious problem. Barriers to existing services tend to persist, including the lack of convenient locations, communication problems, restrictive criteria intake, the unavailability of transportation, limited hours of service, and the problem of not knowing how and where to reach services or care. To help overcome these many impediments and facilitate access to resources, an organized, universal access system is needed to provide reliable information and make appropriate referrals and to forestall the onset of problems, reduce stress, and avoid potential hazards.

To gain knowledge and acquire skills in translating the concepts of social provision into preventive programs, Kendall advises that "appropriate content and methodology be introduced into the curriculum which deals with prevention."[20] What follows is a discussion of how developmental provision was integrated into a series of social policy courses as the conceptual underpinning for the content of each course.

Implications for Teaching

A series of four courses in the social policy sequence of the masters curriculum of the Adelphi University School of Social Work was introduced in 1975, that was designed to integrate the concept of developmental provision as a prevention-oriented approach to policy analysis and program development. In the initial policy course, the duality of developmental provision and primary prevention was systematically traced in teaching the history and philosophy of social welfare and the social work profession, from the provision of the early English poor laws, to the prevention goals of the Title XX legislation of 1974, and to the 1978 report of the President's Commission on Mental Health.

Two subsequent courses dealt with the broad systems of human services, with a focus on the income security system and an emphasis on the organization and delivery of personal social services. The issues involved in providing services to promote the goal of prevention were analyzed and debated in the light of critical policy choices relating to universal versus selective services, social insurance versus public assistance benefits, and the mix of social utilities and case services for balanced provision aimed at prevention.

Based on the theoretical and conceptual orientation to prevention offered in these preliminary courses, a senior Seminar in Program Development was offered as a laboratory for the application of social provision in programming social services

focused on prevention. Students tended to select programs for analysis that were related to their field work experiences. Students for whom it was either not feasible or inappropriate to relate the programming laboratory to their field experience were given the option to simulate an "ideal model" in preventive programming. Utilizing primarily the Kamerman model of phased program development, students were given the opportunity to plan, initiate, or implement service programs, applying the central concept of developmental provision as a strategy to promote prevention.[21]

SOME LESSONS LEARNED

The experience with this series of courses indicates that developmental provision offers a conceptual framework for the teaching and learning of prevention. Although social provision entails consideration of broad social problems and complex macro issues in promoting prevention, the lessons of historical precedents in preventive programming are instructive. A knowledge of human service systems programmed in accordance with the underlying goal of prevention can also offer helpful guidelines. In considering prevention as a goal, students do well to recall Hollister's observation that the etiology of problems is often so obscure and so complex that it is advisable to "humbly pursue some simple, direct, modest goals in prevention programs."[22]

The history of social work reflects a profound and enduring interest in prevention. However, it is important to assess each social action program and legislative provision in the light of the particular era and social climate that gave rise to it.

The students' study of the organization and delivery of human service systems, including the income security system and the personal social service systems, presented a range of policy choices for discussion and analysis. Used in conjunction with the concept of developmental provision, Gilbert and Specht's conceptual framework for structuring "the dimensions of choice" led to the examination of allocation of resources, provision of services to total and target populations, diversified modes of delivery of preventive services, and the assessment of service programs designed for the promotion of prevention.[23] This approach raised some knotty questions regarding service priorities and financial allocations in developmental provision. Should day care be a universal program or a restricted program for poor families? To what extent should programs for the elderly be age-integrated or age-segregated? Will an information and referral service promote a more effective program for prevention as a freestanding service or as an adjunct unit of an existing health or social agency? Can programs be designed to keep something from happening?[24] And conversely, can programs provide something better to happen?

Since students generally selected their field work for analysis in this course in program development, the interface of classroom learning and field instruction seemed to have a significant impact on the students' grasp of developmental provision as a tool for prevention. In developing this conceptual framework, students became aware that, despite their own enthusiasm and commitment to developmental provision in program development, organizational realities often meant dealing with administrative apathy toward preventive goals. The complexities of dealing with bureaucratic constraints and concerns over turf, particularly since the prevention goal often included interorganizational activities and interprofessional relation-

ships, presented significant problems. A hard lesson was the need for professional expertise to test and evaluate the effectiveness of programs designed for prevention and based on developmental provision.

Perhaps the most valuable lesson learned from this experience with the sequence of social policy courses was the need to seek out new ways of structuring or restructuring existing resources with an aim toward prevention. The challenge is to design new social inventions in accordance with the concept of developmental provision.

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5

EVALUATING PROGRAMS OF PRIMARY PREVENTION: HOW CAN WE KNOW IF THEY MAKE A DIFFERENCE?

HELEN REINHERZ

The urgent necessity for evaluation of programs of primary prevention has been identified by both critics and proponents.[1] In the mental health marketplace, competition for diminishing funds is increasing, and primary prevention's share is jeopardized by assertions that preventive programs are launched on unproven assumptions.[2] Long-time advocates of preventive programs, such as Bloom, have also stressed the need for establishing an empirical base for over a decade.[3] Establishing credibility for the preventive programs now in varying stages of development should also result in attracting the optimal quality and quantity of manpower. Only then can the "Fourth Mental Health Revolution" envisioned by the Report of the Task Force on Primary Prevention of the Presidential Commission on Mental Health truly take place.[4]

This presentation briefly identifies several challenges to successful evaluation of primary prevention activities. It then presents some general considerations most germane for preventive programs and discusses specific examples of well-executed evaluative research. The final section of the article offers recommendations for researchers and social work educators.

Although the evaluation of any treatment program is complex,[5] programs of primary prevention present added difficulties because such efforts often have diffuse and multifaceted objectives. For example, a single preventive program for new parents might have multiple objectives: a skill-building objective, such as teaching young parents how to understand infant growth and development; the objective of influencing attitudes toward the growing child; and a further objective of providing an atmosphere in which new parents can share anxieties and obtain emotional support. The question then arises: Which objective should be tapped in evaluation? Rightly, all three should be evaluated. Further questions arise: What is being prevented? Was the program created to prevent later problems in parent-child relationships? Was the program created as part of a larger effort aimed at preventing developmental problems in children living in a deprived area?

Another series of questions addresses details of the program: What intervention was used? Was the method primarily educational, therapeutic? What specific format was utilized? What theoretical framework guided the method? Were there unforeseen circumstances, such as a unique leader or group setting that might explain results? What was the time span given to evaluate the

proposed results? Did the planners expect their program to have only an immediate impact on the parents or children? Did they think of the program as *preventing* parent-child problems for the long-term future? Are there plans to follow the children through the preschool years, through grade school? If so, how many of the parents and children will move and be lost to the study?

All these questions and many more arise in an evaluation of a seemingly simple program. Later sections of the article specifically address these and other issues, which are not wholly unique to the evaluation of programs of primary prevention. However, these issues become problems unless both preventive practitioners and evaluators work together to establish objectives and conditions under which appropriate evaluations may be made.

Roadmap to Effective Evaluation

The conditions for evaluating programs of primary prevention must emerge organically from the initial design of the program. The essentials enumerated here are crucial for preventive programs, which are often critized for having vague objectives and for failing to specify with adequate clarity the intervention and the target population. Additionally, since programs of primary prevention have long-term effects, the follow-up of results is of paramount importance.

SPECIFICATION OF OBJECTIVES AND OUTCOMES

Objectives of programs that point to future outcomes should be realistic and relevant. Klerman reported on the need to modify the goals of a comprehensive program of services to teenage mothers in order to evaluate the program's results. The clinicians' initial goals encompassed almost all aspects of the lives of the mothers and infants over a long period of time. These noble but overambitious objectives had to be tempered with realistic assessments of the impact that several months of education and health care would have for the mother and her infant. The clinicians and the research team delineated several short-range or intermediate goals, which included a healthy pregnancy and the delivery of a healthy infant, and several long-range objectives, including such measures of social functioning as the child's development and the educational and employment status of the mother.[6]

At times the goals of a program can only be measured indirectly. Broussard reported on a videotaped training program for mothers of newborns with the goal of preventing later adjustment problems in the children. The short-term evaluation indicated the mothers' significant shift after training to more positive attitudes towards the infants. Broussard linked these attitudes not only to more positive maternal behavior to infants, but also to expected positive adjustments of the children at a later age (4½).[7] In this instance the researcher utilized findings from previous research to buttress both the short-term and expected long-term results. A greater leap of faith is required with this approach, but at times indirect measures may be necessary because the opportunities for longitudinal follow-up are limited.

Several other issues are important in specifying objectives and outcomes. Klerman et al. refer to the role of the investigator's values in selecting objectives for evaluation. No one can quarrel with the birth of a healthy infant as a positive outcome. However, if graduation from school, a job, and marriage

are selected as outcomes, many clinicians and researchers may consider these values to be middle class and culture-bound.[8]

DEFINITION OF THE PREVENTIVE INTERVENTION

Since prevention is a developing field, many of its newly emerging interventions have not been carefully tested and documented. Also, some of the older methodologies, such as consultation, have numerous variations in form and purpose.[9] Thus, it is essential to specify the independent variable. This is particularly pressing when the impact of a variable is yet to be ascertained or is debated. As prevention activities begin to move into the environmental arena, clarification of the independent variable such as improved housing conditions becomes more essential. Freedman has pursued one environmental variable, "crowding" in living environments. Although animal studies had shown deleterious effects of overcrowding, his work indicated that under certain well-specified conditions in some urban areas, bad outcome did not always result from human crowding.[10] Thus, careful further specification is indicated.

SPECIFICATION OF TARGET GROUPS

Target groups of the prevention program can vary from a total community, to a specific population at risk, to individuals. A program can be directed to professional helpers (consultees), to policymakers, or to clients. Sometimes programs have serendipitous effects and affect groups who were not the original targets of change. As reported by Zacker, Rutter, and Bard, the targets of one mental health consultation activity were police officers; however, evaluation showed that it was the consultant group which showed the most change in attitude. The consultants became more sympathetic to the police and developed a better understanding of the issues and problems in police work.[11]

LONG-TERM AND SHORT-TERM FOLLOW-UP

Prevention may not be forever; however, it must be future oriented. Evalutions must ensure the possibility of adequately assessing the program's long-term impact, although this consideration must be weighed in the light of other requirements. Murphy has noted that major evaluations of primary prevention programs should be undertaken only with populations that are not too mobile.[12] However, the requirement of stability of population must be weighed against the wish to ensure the representativeness of the population served. The population most in need of preventive services may be the most mobile. Also, if stability is considered the most important criterion in selecting a population, this could result in studies of specialized populations, diminishing the generalizability of results. However, some investigators have managed to follow groups over time even when the degrees of attrition varied. Heber[13] and Kellam, Branch, Agrawal, and Ensminger[14] furnish excellent examples of longitudinal evaluative designs.

TECHNICAL CONSIDERATIONS

Program funders and administrators are most convinced by evaluative designs that approximate the classical experiment. Such designs most fully guard against all threats to validity.[15] However, as Weiss illustrates in her volume on applied evaluation, the options of randomized controls does not exist often in the chaotic arena of human services.[16]

Another reason for selecting designs other than the experimental model is the common instability of preventive interventions over time.[17] When the independent variable, the intervention, is subject to change, the purity of the experimental design is severely compromised.

FORMATIVE AND PROCESS DESIGNS

Happily, there are other avenues for appropriately evaluating programs of primary prevention than just experimental designs. There are strong arguments for increased use of formative or process designs for evaluations of primary prevention. A formative evaluation, first defined by Scriven, is most suitable for the early stages of a program's development, which, as noted earlier, is the case with many preventive interventions.[18] Such a design allows for description of the initiation of programs and their early efforts with a variety of groups, including community, agency, and clientele. Through such evaluations, careful documentation can be made of the newly launched intervention. Important information can be obtained both about what exactly is delivered as a preventive service or program and about who receives the service or program.

Some modest efforts in this model appear in the literature. Leutz describes the results of a pilot study of informal networks of care-givers in a Hispanic community. The study documents not only the characteristics of the caretakers and their methods, but also the pattern of referrals when a group of caretakers was informed of the formal agency services available.[19] Although formative designs are most suitable in the early stages of program initiation, summative or outcome designs are appropriate when strategies of intervention and programs are fully developed.

SUMMATIVE EVALUATIONS

When a program is well established, there are a number of suitable designs for consideration. First and foremost is the experiment with its irrefutable logic and elegance. Only a few experimental studies have been cited in reports of evaluations of primary prevention programs, and many of these studies have design difficulties. Polak and his colleagues used an experimental format in the study of crisis therapy for bereaved families. Although the subject families were assigned at random, subsequent analyses revealed that the experimental families had a higher proportion of traumatic and sudden deaths than the control families, thus affecting the results.[20]

Quasi-experimental designs can serve as options when experiments are not feasible. Campbell and Ross used a time series approach to evaluate a program to prevent auto fatalities in Connecticut.[21] The use of a control series design with comparison groups from other states produced a higher assurance that the decrease of fatalities in Connecticut reflected the impact of the strict enforcement of laws intended to serve as deterrents. Although Campbell states that an experiment with randomly assigned control groups is most desirable in the evaluation of new programs, he suggests several optional approaches, including interrupted time series, control time series, and regression discontinuity analyses.[22]

Another design that might be considered for use with individuals, groups, or communities is the single-organism or single-system design initially developed by behavioral psychologists, but receiving wider attention in social work.[23] Although

the single-subject format has been suggested as one of the best designs for evaluation of social work practice in all fields, the social work literature is just beginning to produce examples of such studies.

The complexity of many programs of primary prevention may require combinations of designs. The study of the Woodlawn program by Kellam et al., provides an example of a program to enhance the coping skills of children entering school; the program had the potential to affect individual children, their families, the schools, and the larger community.[24] All such target groups are important to programs of this kind and need to be considered in planning a design. Appropriate measures to tap all expected outcomes must also be considered in planning the evaluation.

MEASURES REPRESENTING DESIRED OUTCOMES

The evaluation of programs of primary prevention requires, above all, the selection of measures that fit the program's specified objectives as precisely as possible. If a program for mothers and babies is intended to enhance the mother's skills as a caretaker of her child and also to increase her self-esteem as a parent, measures must be selected to reflect these objectives. If the infant's cognitive and social development are to be furthered by the program, resources should also be planned to cover precisely these additional areas. If the program is also intended to have long-range effects on the child's school adjustment, measures should be selected for the future goals as well. In short, there should be appropriate measures for each intended outcome.

MULTIPLE MEASURES

Multiple measures should be utilized for all important areas of evaluative interest. If the study is geared to increasing competence in children through training in problem-solving, the investigators should gather data to reflect the children's ability to solve specific problems in a test situation.[25] However, the study would be enhanced by observations, sociometric data, and information on performance at school and home. In many instances, it may not be possible to utilize more than a few measurements, but more are better than less.

Programs of primary prevention often need to measure behavior or the nonoccurrence of behavior or events in the future. Thus, at times measures may be utilized that stand as proxies for the direct behavior. These alternatives are discussed in the next section.

TYPES AND SOURCES OF INFORMATION

The same types and sources of information are available to all evaluators. These include measurements of attitudes, beliefs, behaviors, and performance. Data sources can include clients, schools, social agencies, and professional judgments. They can also include reports in the media and official records, such as school reports and census data.

Although each type of information has merit in specific instances and several can be used to confirm each other, the best and most convincing measures are those that represent actions or behaviors. Thus, the number of recorded arrests is a good measure for a delinquency prevention program. The planners of

such programs might want additional evidence, such as general adjustment at school or home, but arrest and nonarrest are clearly specified and unambiguous. If a program for teenage pregnant girls chooses the delivery of a healthy baby as a goal, that, too, is a clear, measurable outcome.

However, there may be occasions when it is not possible to measure such objective, observable outcomes. For example, Doering and Entwisle contrasted a group of mothers prepared for childbirth with a group of women who were unprepared. The authors hypothesized that the prepared mothers would not only express more satisfaction with their deliveries, but also have more positive reactions to the baby. Reactions to the babies were secured through verbal statements, but the investigators also noted closeness to the infant as indicated by rooming-in arrangements and breast feeding. Choosing to have the baby in the mother's room and to breast feed offered unobtrusive measures of positive reactions on the part of the mother. These authors did not discuss the implications of the maternal reactions to the child.[26]

In contrast, another investigator assessed the impact of televised programs concerning issues of child rearing. The programs were used for anticipatory guidance of women bearing their first children, and instruments were designed to measure the mothers' perceptions of the infants. One instrument chosen had the additional property of predicting the children's adjustment at the age of 4½. Thus, the investigator was not only interested in measuring current perceptions of the children, but, more important, the children's future adjustment.[27]

In both programs just discussed, the behavior or response chosen as the outcome measure is intended to represent another behavior or attitude or the future mental health of a target group. Often such indirect outcome measures are all that are available to the investigator. However, their credibility is enhanced by having multiple indices. In the Doering and Entwisle study, positive attitude was measured by mothers' statements and several actions—rooming with the infant and breast feeding. Future sequelae of these short-term results can be extrapolated from reports of other studies or theoretical considerations.

CONSUMER SELF-REPORT AND PROFESSIONAL JUDGMENTS

Often the only measures available to tap the outcome of an intervention is the consumer's self-report of satisfaction.[28] Such testimonials are weaker than other types of evidence of program outcomes, and it is strongly recommended that, whenever possible, information from other sources be added to strengthen self-reports.

Clinical judgements have been used in many studies in the mental health field. Traditionally, they have been used to measure the status of mental health, adjustment, and coping. In spite of efforts to standardize judgements, there are major problems in securing adequate reliability. Clinical judgments have the added disadvantage of being an expensive form of data to gather because of the high level of professional expertise involved.

In summary, each type of measurements and each data source is appropriate under specific circumstances. Choice should be dictated by the type of program and its goals. Measures should be chosen that clearly demonstrate the impact of the program to those responsible for staffing the program and also to those responsible for funding and sanctioning it.

Sample Program Evaluations

The several studies of primary prevention that have been fully described in the literature focus on work with children. Heber produced a carefully documented study of a program aimed at preventing mental retardation in infants born to retarded mothers in poor neighborhoods.[29] Children and their mothers were assigned randomly to control and experimental groups. All steps of the interventions with mothers and children were documented, including changing emphases as the program developed. Standardized measures of the mothers and children were used, but so were observations of interactions, reports of professionals, and, most important, reports of behavior and activities.

The children's mothers (all with intelligence quotients of 75 or below) were trained for employment, and at follow-up three years after the program's end, most were stably employed and earning approximately forty dollars more a week than control mothers. There were important unresolved issues in the relationships between the mothers and their children, however, and in the mothers' capacity to resolve their family, social, and community conflicts.

The careful documentation from the birth of the children to entrance into public school is impressive. However, Hunt criticized the study for its initial disparities between experimentals and controls and for a lack of specificity in the intervention.[30] Another possible criticism of this thorough effort is that it was obviously an expensive enterprise that will be difficult to emulate.

The work of Kellam et al., is another model study both in the program's scope of activity and in its longitudinal character.[31] It is also well documented because a sizable number of publications have described the work of the program.

In the field of social work education, a number of schools that are funded to train students in primary prevention are designing evaluations of their programs. Since specific instruments to tap attitudes reflective of a preventive orientation are not widely available, many institutions must construct their own measures or use others broadly reflective of the goals of community mental health.[32]

One approach to evaluating training in primary prevention is to use key concepts to identify issues of particular salience for the specific training program. The evaluation of one training program focusing on infants and young children used this approach in a design contrasting students in the prevention program with all other students. Measures were taken before the training began and at the end of each year of study. This design allowed for measurement of change over time and for an initial comparison of the two groups. An additional attribute of the design was that it obtained data from the students' teachers, field supervisors, and community agencies to assess the impact program upon the students.[33]

Challenges

The challenges of evaluating programs of primary prevention are great, but exhilarating to those who like to solve new problems. The scope of program

design is so broad that evaluative methods must be created to measure all the relevant components. Some emerging modalities of primary prevention, such as natural helping networks, are still in the early stages of development and, consequently, are especially difficult to measure, but they clearly must be studied.[34]

There are some gaps in the training of social work researchers to evaluate programs of prevention. Bloom has mentioned a number of them, particularly the current lack in schools of social work of training in the public health research technologies of epidemiology and biostatistics.[35] Schools are just beginning to teach the use of single-case designs and quasi-experimental approaches, which are appropriate methodologies for evaluating preventive programs.

All these technical issues are important. However, it is even more crucial to raise the consciousness of all social work educators as to the scope, promise, and value of mental health programs that seek to prevent human suffering and misery and to promote active coping.

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6

TRAINING IN PREVENTION: AN EDUCATIONAL MODEL FOR SOCIAL WORK STUDENTS

DIANA TENDLER and KAREN METZGER

As current trends in health care have broadened the scope of services to encompass goals of health preservation and promotion, as well as cure of disease, there is a need for social work education to examine further its methodology for the training of future health practitioners. This paper is a report on a fieldwork model with the intent of demonstrating a program in learning and teaching that could extend our understanding of educational patterns for preventive practice in the social health field.

The rationale for the program came from an appreciation of the need for an enhanced familial, developmental, and consumer orientation as an underlying base to issues in preventive service delivery. Much of this conviction came from work done in crisis intervention that suggests a view of certain crises as normative and related to changing demands of the life cycle.[1] Additionally influential was a concern with developing readier access to populations that might benefit from early intervention and anticipatory guidance.[2] Observations of certain limitations dealing with the dysfunctional consequences of illness and disease, where social work intervention is often at late points in the history of the problem, were an impetus to the consideration of a setting in which prevention might more easily be taught.

A public health agency, with its historical attachment to preventive strategies, and its mandate to serve broad health needs in the community, seemed a likely locus for the demonstration of training in prevention. Agency structure and clientele were seen as providing opportunities for the development of student role skills in encouraging populations to become activated consumers of health and welfare services. The public health field's expansion into community outpatient clinical services in maternal and child health, and its emphasis on educational functions to individuals and groups "at risk," underscored its potential for teaching prevention as a primary goal. Child health practitioners have long been impressed with the initial participation of high-risk clientele in prenatal and well-baby clinics, and their subsequent failure to continue to use community health services except at points of emergency. Such groups make a logical target for early social work intervention around the anticipation of ongoing health care needs, the emergence of family life

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cycle difficulties, and educational exposure to the range of community resources that might assist families.

It was within such a framework that a public health setting offering ambulatory medical care was utilized in the development of a model for learning and teaching. Pairs of 2nd-year graduate students were assigned to work regularly in one of three neighborhood health centers. The centers were selected because of their potential to provide meaningful experiences in identification and treatment of families known to the Health Department. The major focus of student efforts was within maternal and child health; assignments for coverage of weekly pediatric, maternity, and adolescent clinics were the base for student case load and responsibility within the centers.

The aims of the demonstration—practice in early intervention and aid to family processes for the benefit of clients and the learning needs of students—focused on the following educational and service objectives: (a) case finding and development of methods for early contact with families; (b) explication of social and educational approaches in assting families to respond to changing demands within the family life cycle; and (c) examination and implementation of feasible and desirable patterns of interdisciplinary collaboration on behalf of families.

The process by which these aims were to be realized in the fieldwork experience involved an orientation of student to project purposes, elaboration of intervention methodology in line with the three major educational and service objectives, and some additional efforts in the area of research and evaluation.

Orientation to the Project

Orientation of students to the project and special considerations for aspects of practice in public health settings were introduced very early in the placement, with the following emphasis: (a) introduction of public health concepts in the context of teaching about the "system"; (b) the implications of differential social and demographic characteristics of the respective communities for client population needs; and (c) the meaning of preventive health service as it might affect student approaches to clients.

In the first of these, historical trends and the recent shifts within public health work into direct delivery via outpatient clinical services were explained in the students' initiation into potentials for social work and collaborative practice. Concepts of levels of prevention, early case finding, and sensitivity to epidemiological determination within a community framework were stressed along with specific elaboration of the staffing patterns and interdisciplinary character of the work.

In community descriptions, the implications of certain sociocultural elements for expected interventions were presented. Each center has rather distinct differences in community population mix: A blue-collar community with an unusually high population of recent immigrants from the Caribbean, Latin America, and poorer southern European countries presents issues in health practice often related to adaptation to a new culture; another more closely approximates the characteristics of an inner-city black population, with the added suburban complexity of poor mass transport and little geographical accessibility or experience with regular use of health services; the third represents lower and middle-class whites residing in a suburban sprawl who

appear more "educated" toward implications of health care.

The beginning emphasis on the demands on a worker delivering preventive services, and the view of the client as a user and potential consumer of health services, was aimed at moving student consideration from a problem focus on pathology and illness to a more balanced and comprehensive evaluation of assets and liabilities within a family focus. Much of this initial orientation was carried out in group meetings; its intent was to set some expectations for a framework of practice that would include awareness of the wide range of activity that would be required in the field setting. This was further supported by discussions and materials on agency philosophy and practice by the health center staff.

Methods for Intervention

The family as the focus for attention and conceptualization as to the impact of health status of various members on the family unit underlies the approaches that have been developed. Sensitivity to sociocultural factors impinging on family functioning and the role of the community and social environment as enhancing or nonsupportive are also of significance to the manner in which students' preventive social work efforts can be effected.

IDENTIFICATION AND CASE FINDING

Each year, students took responsibility for social work coverage of approximately one-third of all the weekly sessions in pediatric, maternity, and adolescent clinics in the three neighboring centers. Routine screening of cases was the mechanism utilized in regard to identifying populations "at risk" and situations in which there were alterations and possible disturbances of family equilibrium. Based upon available epidemiological data in the Health Department, they included the following categories and criteria:

—All first-time users of health center services in pediatric, maternity, and adolescent clinics assigned to the student.
—The impending birth of a child. Particular populations in this group included first pregnancies, birth of siblings, all pregnant women under 21 years of age, single mothers, and pregnant women with a known history of prior mental or emotional difficulty. .
—Traumatic events affecting parents and children, using indicators such as separation and divorce, accidents, unemployment, illness, hospitalization, or death of a family member.
—Children's problems, evidence in developmental lags, learning disabilities, chronic illness, and failure to thrive.
—Adolescents with developmental or phase-specific problems in school and social adjustment, parent-child conflict, special physical or psychological difficulties, and evidence of problems in family life affecting the adolescent.

CASE COVERAGE

The initiation of social work activity was at first dependent in large measure upon the implementation of the above guidelines circulated among clinic staff members of the various disciplines to alert them to refer such clients. Additionally, other situations emerged in the course of collaborative contacts. Further elaboration and new methods were developed during the second year to ensure the opportunity for such

exposure, particularly for clients "new" to the Health Department. Since the first entry point at which potential clients are identified is in requesting clinic assignment or appointments, students assisted by the receptionist are enabled to make a very early contact with the new user. Students often call the client prior to the first clinic appointment to determine availability for an interview during clinic time or arrange for a more appropriate time to see them. New clients are also approached in the waiting room and advised of the social worker's availability to orient them to health center services. The agency's community service aides, whose field assignments bring them into contact with persons in need of service, have been encouraged to make referrals. Such methods have resulted in more effective coverage of new clients at the significant point of initial contact with the agency.

Such screening by the students was usually followed by psychosocial assessment; if such evaluations suggested the need for continuation, a "contract" for such contact or, if indicated, referral to appropriate community resources was made. A psychosocial study guide, developed by the field instructor, which took into account a broad spectrum of developmental and environmental information as well as current concerns, enabled the worker to anticipate and plan interventions. Methods for client contact included interviews at the health center, home visits, and various follow-up procedures when appointments were broken. The emphasis was on establishing a pattern of continuity of care, and informing and educating the new patient, as a health consumer, of the nature and extent of health services available to each family member, either within the health center or in the community. Treatment processes made use of individual, family, and group modalities. Particular emphasis on family interviewing underscored the significance of the family unit and the impact of care on each family member. Extensive use was made of collateral contacts with other health providers, schools, psychometric facilities, legal services, and protective, child welfare, and financial divisions of the public welfare sector.

Assisting Families to Respond to Changing Needs

The emphasis on providing impetus for self-directed activity and the promotion of skills in the direction of more effective life management is a major focus of the interventions in which students engage. The family unit is highly significant to such processes, and increasingly the focus on health promotion and avoidance of dysfunctional consequences has actively taken family status and behavior into account. Family interaction is recognized as a dynamic flow, which affects and is affected by the health and/or illness of its members. Students in their psychosocial assessment are attuned to evaluating the degree to which the family is able to serve as a natural support system or where it may fail its constituents; the role and function of all members, including kin and significant others, is included in such study.

In this approach to families, using current status as the base for consideration of total family needs and development, the workers' interaction with clients must take into account the range of family needs presented, must attend to the priorities they can anticipate in an attempt to avoid further dysfunctional consequences, and share with clients, via the "contract," the directions and efforts believed to be most useful. Three levels of assistance are utilized: (a) assistance with social work services provided by the students; (b) utilization of other public health services within the agency; and (c) assistance in negotiating the outside community resource system. Cases may require all three levels of intervention.

The frequent use of home visits often created an opportunity to connect with significant others in the family constellation; assistance has been given to unemployed family members, in arranging home health care, food stamps, and in crisis of illness or death of a family member. Such visits also provided more active knowledge of environmental conditions and enabled interventions designed to improve such areas as poor housing conditions, lead poisoning situations, and other hazards.

In addition to individual and family contacts, expansion of group methods in the second year's work suggested at least two levels at which such work is meaningful in supporting client functions: (a) "orientation to care" groups, often conducted in the waiting room with clients where the content is focused on explaining the clinic system, the range of services offered, and the work of various clinic practitioners; and (b) groups formed around particular conditions and concerns that clients mutually share. They may be of fixed duration, as in work with young expectant mothers attending the maternity clinic and being prepared for birth and subsequent management of a new baby in the home, or in regard to more chronic problems such as obesity and parent-child relationships.

Students have been extremely creative in their sensitivity to how such groups emerge from the natural setting, and their skills in group formation have increased over the course of the two years. The nature of individual and group process carried out by the students has increased in depth and coverage. Some 110 families were seen during the first year and 175 during the second year, and the interventions can be seen as increasingly more relevant to client assessment, treatment planning, and the family's ability to exercise more options and choices. The student worker's range of roles can be more precisely specified as including functions in addition to the usually identified areas of help in elaborating client need and acquainting them with appropriate resources within and outside the agency. The more usual demands of the setting and client group also promote an *educative* function so that such a consumer becomes aware of the availability, accessibility, and comprehensiveness of health care for all family members. The student worker also serves as an *advocate* in assisting the client to be informed about health resources, to maximize utilization, and to examine and understand more appropriately the levels and quality of care. Similarly, the student worker may bridge and *coordinate* access to other types of community institutions (e.g., school systems, welfare services, and agencies concerned with housing and environment). Thus, the notion of health promotion, as a major function of worker and setting, assumes greater importance and leads to an interventional stance that can impact on many aspects of client and family life.

The Collaborative Process

The multidisciplinary character of the agency, wide concern with an extraordinary range of environmental, social, and physical factors, and the heavy reliance on the concept of collaboration as the mechanism for the achievement of its public social goals emerged as a central focus in student learning. Because the collaborative process itself can be experienced both as enhancing and conflictual, issues arise in regard to role complementarity and impact upon the expectations, perceptions, and behavior of involved practitioners from the many disciplines.

The plan for the project envisioned the necessity for exposure to learning about such practice. The content of daily "logs," required as part of the student's induction into the setting, demonstrated a shift from initial role diffusion to an

awareness of the cooperative and enhancing character of collaborative relationships. Early concern over "turf," the threat posed by the entry of the students to other staff members, and the struggle to understand the validity and uniqueness of varying contributions were originally perceived by the student as impediments. However, daily field practice in the health centers provided no escape from the need to recognize dependency on other agency personnel and disciplines as a "fact of life." Exposure to the skills possessed by other disciplines within the framework of health-promoting goals encouraged a greater degree of respect for shared practice; explanations of communications difficulties took into more active account different substantive frames of reference, levels of formal responsibility, as well as interpersonal factors, and assisted in the beginning elaboration of techniques and styles of effective interaction.

Considerable emphasis and teaching to these points took place in individual and group supervision. The use of the logs on agency contacts and impressions was a valuable tool in making questions about the character of intra-agency relationships more explicit. In fact, this area over the two years showed some of the greatest movement as it touched on many facets of the students' work and agency program. Some examples are:

1. Co-leadership in group processes. For example, the head nutritionist and the social worker deal with a "weight group" of obese women; clinic nurses and a physician join the social worker in a maternity group; all types of health center staff participate as resource persons in an adolescent clinic group.

2. The involvement of nursing and medical staff in the interpretation of medical findings either to worker, client, or both.

3. Contact with other programs and departments within the agency. The department epidemiologist and biostatistician provided and interpreted Health Department statistics as they contributed general understanding of health service and delivery and particularly to a student's interest in data on the incidence and prevalence of teenage pregnancy in the county.

Research and Evaluation Efforts

In the identification of such needs, movement toward a base for evaluation of learning and teaching functions has begun. Although some of it remains on a descriptive level, and attempts to tease out classificatory principals are rudimentary, areas in which starts have been made include:

1. A research project in which all students were engaged in collecting case data on a pilot study of the outcome of screenings done in the first semester. As a preliminary effort to gain some insights into the impact of social work screening on continuity and quality of care, it may also serve to indicate problem areas in data keeping and methodology as well as some initial feedback as to client response.

2. Expansion of student understanding of epidemiological data as it affects social problems with which the workers deal. The examination of county rates on live births, abortion, and fetal death, in regard to teenage pregnancy, is but one example of such activity.

3. Elaboration of community institutions and their resource potential for clients was undertaken in a study of school health programs; the character of health education, personal hygiene, physiology, preparation for emotional and physical readiness for adult life, and parent education. Such a study pattern may well be applicable to other types of community organizations.

Student Learning and Educational Aims

In all of the above, the students' experience emphasized the development of and appreciation of aspects of health care much beyond the interventive skills called for in an immediate situation or problem posed for solution. In addition to usual teaching around case contacts, attention was also given to the informational base for what is healthy or normative, recognition of age- and phase-specific needs, sensitization to the role of specific social and c ultural factors, and examination of the client's and the agency's attitudes and expectations of health care. The shift from a more pathological orientation stressing factors reducing client movement, to an understanding of those contributing to more maximal activity toward health maintenance and promotion, was encouraged both by the expectations for activity in case assignments, and formal individual and group teaching by the field instructor.

In addition to individual supervisory process, weekly group meetings attempted to carry out broader educational objectives including the following topical areas:

1. The expansion of content in regard to public health concepts, levels of prevention, "at risk" populations, epidemiology, and the promotion of community health.

2. Information on health and illness, with particular reference to the impact of certain disease entities, their course and treatment as it affects social functioning and intervention.

3. Assessment processes with (a) particular emphasis on early identification and case finding and (b) sensitization of students to their own attitudes and expectations of the health care system.

4. Interventive techniques and options with individuals, families, and groups; short-term care; worker-client contracts; and use of community resources.

5. Practice issues such as agency procedures, confidentiality, consultation, recording, collaboration, and collaterals.

6. Social issues, problems, and conditions, especially those involving public attention (e.g., abortion, child abuse, human sexuality, substance abuse.)

Such learning sessions emphasized family life and development as the background for identification, assessment, and treatment planning. Using the concept of the normative tasks and adjustments associated with various age levels, and the role requirements for all family members in regard to such phases, student activity could then be geared to a broader consideration of alternative consequences emerging from their interventions. Social and environmental considerations affecting the quality of life, having to do with ethnicity, subculture, economic and social status, and suburban living patterns, were also discussed as part of the context for case evalu-

ation. Bibliographies and assignments related to content were developed for group and student reports.

Implications for Further Development of the Educational Model

The first two years of experience in clarifying means and goals have assisted in pinpointing ways in which such curricular planning can continue to be developed. Areas in need of further refinement for teaching and learning purposes include:

1. Greater appreciation of the impact of the public health "system" as it strengthens health promotion within service delivery patterns and has implications for direct practice and collaboration.

2. Continuing emphasis on the education of the client as a consumer of health services with options and rights, underscoring the nature of the worker-client contract as it influences planning and response to care.

3. The focus on family growth and development to be implemented by study of life cycle demands, sociocultural factors, and the impact of disturbances in health of family members on both family and individual functions.

4. More understanding of demographic and social characteristics of the community as they relate to client problems, behaviors, and responses, and affect issues in provision of service.

5. Further evaluative activity that would elaborate unmet needs and gaps in service; application of epidemiological data to service delivery; follow-up of client progress in response to early identification and intervention. These areas are seen as helpful in beginning to explicate research methodology for ongoing examination of the impact of preventive social work activity.

This article has dealt primarily with work in a field setting and patterns by which students have become involved in practice efforts that enhance their awareness of preventive methodology. Clearly, there are many other ramifications, which affect such areas as the school's academic curriculum, the host agency, and the potential impact of such learning on professional settings and practitioners, which we plan to elaborate in other presentations. In the interim, however, we feel that these materials indicate how the opportunity to focus on early intervention and to gain access to a range of community populations has been greatly enhanced by the public health setting with its emphasis on the broad view of the community matrix, its epidemiological orientation, and emphasis on populations "at risk." What emerges from this initial observational period is the challenge to operationalize, in even more refined ways, the ideas and principles with which we have so heartily concurred—to move our commitments to prevention into methodology.

Notes

1. F.E. Cyr and S.H. Wattenberg, "Social Work in a Preventive Program of Maternal and Child Health," *Social Work*, Vol. 2, No. 3 (1957), pp. 32-39.

2. C.H. Meyer, *Social Work Practice: A Response to the Urban Crisis* (New York: Free Press, 1970).

7

INTEGRATING SERVICES FOR HEALTH PROMOTION

SALVATORE AMBROSINO

In the provision of social services, the variety of program designs is almost endless. The position presented here is that counseling, family life education, and family advocacy are a logical and powerful group of services that combine to create a syngergistic impact. The fundamental relationship among them is relevant to many kinds of service organizations, especially to the family service agency, which helps individuals and families cope with a wide variety of emotional and social problems.[1] It is difficult to categorize family problems as essentially emotional, and thus requiring counseling; or as a lack of understanding of human relations, which requires a program of family life education; or as a critical social problem, which requires an advocacy intervention. Most often, the problems presented in social agencies are a complex blend of emotional and social difficulties that require the coordination of different services in a variety of sequential steps.

Goals of Counseling and Family Life Education

The successful development and coordination of counseling and family life education programs demand an understanding of their differences and similarities. Counseling in agencies usually focuses on relationship that cause distress; on reality problems, such as the need for housing, employment, or health care, which necessitates a referral to another resource; or on conflicts with another agency, involving, for example,unjust policies or serious deficiencies in services. Counseling centers on emotional problems. It is directed primarily to conflicts that bind and misguide energies, and the client is helped to become aware of feelings and of the conditioning of past relationships or expectations that create stress. The objective is to free these energies for more rational and appropriate behavior. The goal of family life education is different. According to Neubaur: "Education is aimed at those faculties of the ego which are undisturbed by conflict. It is oriented to healthy factors of the personality, and appeals to the ability to judge, to learn

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by experience, to gain understanding, to plan, to make choices, to adapt to changing circumstances."[2]

Although the basic approaches are different, there is some overlap between counseling and family life education. The counseling process in its various forms—one-to-one, conjoint, group, and family approaches—also appeals to the conscious ego strengths of clients by providing information about personality development and interpersonal relations. In turn, it is possible for participants in family life education programs to acquire greater understanding of their behavior or the dynamics of stressful relationships, and this understanding opens avenues for emotional relief and improved functioning. The therapeutic effect of a family life education program may be similar to positive life experiences, such as exchanges in close relationships or the impact of literature, theater, or other arts.

How Family Life Education Works

Although the gains from a successful experience with counseling or family life education may appear similar, it is critically important to understand the differences in process and to safeguard them in the respective services. It is necessary to establish clear contracts of what the agency is offering and what the client can expect. For example, the leader of a family life education group might explain the series of sessions as an opportunity to talk about the areas of most common and urgent interest and to share ideas, feelings, and experiences. The leader emphasizes that the group does not solve individual problems, but does increase the understanding of selected problems. If, despite this explanation, members at times ask the group to solve individual problems, the leader is obliged to remind the group of its purpose.

For example, assume a group of parents of preschool children focus on the subject of toilet training. As the discussion unfolds, one of the parents expresses tremendous anger at the inability of her 3 year old to become toilet trained. She asks the group to help her understand why she is so upset. After reminding the member that this is not the focus of the group, the leader guides the group to explore the many aspects of the subject: what toilet training means to children, how the various parents react to the adjustment, the range of parent approaches that appear to be helpful and not helpful, when sphincter control is developed in children, and other aspects the group wishes to examine. The leader poses questions, solicits responses to contributions, and furnishes information to balance the content so that important dimensions are included. This overall review of the subject aims at enlarging the members' understanding of this developmental period so that each participant is in a better position to understand and deal with his or her particular situation. Each contribution is helpful to this effort; the parents who are successful and those who are struggling both help to develop a full perspective on the subject.[3]

Family life education programs may use reading materials, films, skits, or plays and take the form of a single meeting, a series of meetings with different topics, or an ongoing discussion group (usually eight to fifteen members) that establishes its own agenda and meets regularly, most frequently on a weekly basis for anywhere from six to ten weeks.[4] In addition, a variety of home-based programs teach parents how to improve the cognitive and social development of their preschool children.[5]

Function and Scope of Family Advocacy

The third service component essential for health promotion is family advocacy. Social agencies have historically helped families suffering from social problems. In the 1960s the need for this effort became more pronounced. The term family advocacy evolved in the family service field to describe the variety of techniques social workers used to help clients who were having difficulties in obtaining necessary assistance from communit y resources. A family advocacy program is an agency commitment which recognizes that social workers must give the same attention and level of skill to helping clients with social problems as with emotional problems.[6] For many agencies, it means taking a further step—to move from case to cause. This requires gathering data to document unjust policies or serious gaps in institutional programs and developing advocacy actions in concert with the families affected and other resources. An agency is bound to be overwhelmed by the variety of institutional shortcomings that threaten family life. The selection of issues for advocacy actions must be based substantially on data from the experiences of the agency. The extent to which other agencies should be involved or encouraged to assume leadership in coalition efforts must be weighed. The task of assembling agencies to develop a joint strategy for advocacy seems to fall most appropriately to the agency that can provide the most significant documentation of how the social problem undermines families.[7]

The staffing pattern for a family advocacy program varies. It ranges from a commitment by an agency's staff with supervisors and administrators offering backup and training resources, to a separate department with its own staff of one or more. In most agencies a board committee or a board-staff committee, sometimes in conjunction with community representatives, acts as a planning and advisory group to help select priorities and develop strategies.[8]

Relationship of Counseling and Family Life Education

All three component services are essential and should be closely integrated to maximize service effectiveness. Counseling is a basic service offered by most multiservice centers. Programs of family life education are increasingly widespread in the family service field [9] and in community and educational centers, but are not generally regarded as having the same value as counseling. Not every client wants counseling or needs it or can face the threat it poses when it is needed. Agency programs, however, are frequently not designed for this reality. Family life education activities provide a unique opportunity for group members to learn to listen and to express concerns, clarify confusions, give and receive support, and review options for improving relationships. They put people in touch with other people so they can help each other. This type of service thus meets a critically important need: it is prevention-oriented and opens the way for many individuals to obtain service who might otherwise not apply.

Family life education and counseling should be viewed as having equal potential for helping families. They should also be promoted as part of a continuum in the helping process. Frequently, individuals in counseling can also benefit from a family life education experience, which affords the opportunity to compare children, marriages, and responses to life adjustments. The special value of a group is that members discover the universality of human problems and derive substantial support.

Counseling and family life education can thus be mutually reinforcing: the insights and knowledge gained from counseling might be relevant for the group, and material from the group might be brought to counseling to apply to particular conflicts and adjustment problems. Moreover, the family life education group may help members recognize or accept that they have special problems which require counseling, and counseling may help clients realize that there are no easy answers and that exploration in an educational group can provide a greater appreciation of the human scene.

Family life education groups are especially effective in reaching out to such high-risk groups as minorities, youth, the poor, and the aged. The contact in recruiting is nonthreatening and can be seen as a social and educational opportunity for target populations that are isolated and feel stigmatized.

Family Advocacy: Integral Part of Services

Both counseling and family life education should operate in a framework of advocacy that gives workers support and guidance to help clients and groups suffering from social problems. It is a mistake to see advocacy simply as an adjunct service; rather, it should represent an essential purpose of the agency. For example, family service agencies are in a unique position to observe how programs and procedures of organizations undermine families, and the agencies have a responsibility to help families fight such failures and to use such data to change systems.

It is necessary, therefore, to integrate the three approaches into the philosophy of the agency and into the statement of its mission and goals. The three programs can be conceptualized as three possible doors through any one of which a client may enter the agency and then be routed to the other doors if necessary. The family advocacy door should be visible and, in some agencies, take the form of a crisis intervention center. Thus, in addition to promoting family advocacy as an integral part of its complement of services, along with counseling and family life education, the social agency can feature family advocacy as the paramount service of some program units. This spotlighting serves to interpret the basic purpose of the agency and to reach out to disadvantaged groups in dire stress.

An especially important place to integrate the three services is in long-range planning. In the design or shifting of program emphases; a planning structure of board members or board members and staff can strive to develop the three basic services in a suitable mix for community needs and to foster their close coordination. If the planning process is not locked into the traditional pattern of considering one program (usually counseling) as its response to the identification of an unmet need, but is open to the possibility of using counseling, family life education, advocacy, or all three, the chances for imaginative program development are increased.

The administrative structure of the agency offers another vital means of connecting information and decisions about the three services. The staff performing the different services should have access to the planning and policymaking process. In some settings, generic workers will perform the three services, and in others, workers may be specialized. Whatever the staffing pattern, supervisors or administrators in charge of counseling, family life education, and advocacy should be part of the administrative structure that participates in decisions about program implementation.

In summary, then, it is proposed that the integration of counseling, family life education, and family advocacy increases the effectiveness of efforts to help families

with serious problems. Counseling assists individuals and families to resolve conflicts and frees energies for constructive use. Family life education builds on the strengths of individuals to extend knowledge of personality development, interpersonal relations, and the influence of environmental factors on behavior. Advocacy helps individuals to negotiate institutional systems and obtain needed services. The three programs pursue strategic paths to help individuals and are inextricably related, just as the emotional and environmental factors are bound together in family crises. The program planner who wants to reach out to vulnerable groups such as the poor, youth, minorities and the aged, is best advised to initiate contact with the offer of family life education or advocacy assistance, rather than with counseling.

If this trio of services is to become more widely available, agencies will have to focus more attention on family life education and advocacy. This requires a greater conviction that families can learn in educational programs and that the agency has a responsibility to help families suffering from institutional injustices and critical gaps in service.

Issues for Social Work Education

The social worker who provides family life education or advocacy assistance as either a specialized or generic worker is invariably trained by agencies to perform such services rather than by schools of social work. The emphasis in group work training in schools of social work is frequently on the social development of group members and increasingly on group therapy. I suggest greater attention to the group education process in relation to content areas in family life. It is also important to teach more about the normal development of children and the everyday problems of families. Most social workers are oriented to pathology and are not adequately prepared to guide discussion in family life education.

I suggest further that family advocacy be taught as an integral part of counseling and family life education. Social work students should be trained to be as keenly alert to the importance of exploring social problems and their remedies as to exploring emotional difficulties in both counseling and family life education groups. By studing case histories social workers can learn when to help clients act in their own behalf in advocacy actions, when to act together with a client, and when to act for the client. Whatever approach or combination of approaches is used, it should be based on a diagnostic assessment of what promises to be most effective in helping the client therapeutically as well as resolving the problem. Understanding the variety of service systems, the techniques for advocacy interventions, and the development and constructive use of political pressure should also be part of the curriculum. Social workers should understand the need for agencies to move from case to cause and how to develop the steps in such efforts. A final important dimension in training social workers for advocacy is to help them deal with any of their own emotional responses that might interfere with effective functioning in the role of advocate.

Notes

1. Patrick V. Riley, "The Family Service System: Unity within Diversity" (Keynote address, Family Service Association of America, Biennial Conference, Boston, October 1975).

2. Peter B. Neubauer, *The Technique of Parent Group Education: Some Basic Concepts* (New York: Child Study Association of America, 1952), p. 12.

3. Aline B. Auerbach, *Parents Learn through Discussion* (New York: John Wiley & Sons, 1968).

4. Frank Cheavens, *They Were Better Parents after Group Discussion* (Austin, Texas: Sable Publications, 1974).

5. Barbara Goodson and Robert Hess, "The Effects of Parent Training Programs on Child Performance and Parent Behavior," unpublished manuscript (Stanford University, Palo Alto, Calif., 1976).

6. Ellen Manser, ed., *Family Advocacy: A Manual for Action* (New York: Family Service Association of America, 1973).

7. Robert Sunley, "Family Advocacy: From Case to Cause," *Social Casework*, Vol. 51 (June 1970), 347-57.

8. Robert Sunley, "Advocacy Process and Intervention Techniques," mimeographed (Paper presented at Family Service Association of America, Family Advocacy Institute, Zion, Illinois, June 7-10, 1978).

9. Salvatore Ambrosino, "Family Services: Family Service Agencies," *Encyclopedia of Social Work*, 17th ed. (New York: National Association of Social Workers, 1977), pp. 429-34.

PART 3

ANNOTATED BIBLIOGRAPHY IN PRIMARY PREVENTION

8

BIBLIOGRAPHIC ANNOTATIONS

MILTON NOBEL and BARRY M. PANZER

This annotated bibliography is intended for use by students studying prevention as well as by the book's principle audience of faculty interested in curriculum development in prevention. The following classifications around which the annotations are organized were derived from examination of the interdisciplinary literature used in primary prevention courses offered in programs of social work education:

1. Theoretical Considerations in Primary Prevention
2. Social Work and Primary Prevention
3. Prevention Programs
4. Social Competence
5. Social Support Systems, Natural Helping Networks, and Self-Help Groups
6. Family Life Education
7. Adult Education
8. Epidemiology
9. Evaluation
10. Criticism and Limitations of Primary Prevention

THEORETICAL CONSIDERATIONS IN PRIMARY PREVENTION

ALBEE, GEORGE W., and JOFFEE, JUSTIN M., eds. *Primary Prevention of Psychopathology. Vol. 1, The Issues.* Hanover, N.H.: University Press of New England, 1977.

This volume consists of the papers presented at the First Vermont Conference on the Primary Prevention of Psychopathology. The papers cover a wide variety of subjects, including problems of definition; techniques of identifying high-risk individuals and interviewing for primary prevention; genetic, prenatal, and perinatal factors in prevention; and state and federal prevention efforts. An appendix contains almost four hundred references.

BLOOM, BERNARD L., "The Medical Model, Miasma Theory, and Community Mental Health," *Community Mental Health Journal* 1 (1965): 333-38.

The author argues that the principles of miasma theory rather than the medical model usually associated with mental illness, should be considered as a legitimate base for elaborating a methodology of primary prevention and for a community mental health model. Miasma theory preceeded germ theory as the major explanation of disease processess in the Middle Ages. Miasma theory held that soil polluted with waste products of any kind gave off a "miasma" or poisonous substances into the air, which caused most major infections of that period. The early public health movement was miasmatic in its approach. Early environmental and sanitary engineers sought to prevent disease by: (1) removing and preventing the accumulation of filth or by promoting sanitary conditions and (2) by alerting the potential victims to the dangers of their environment by public education.

Current concepts of primary prevention of mental disorder appear to be designed to remove existing accumulations of psychic sewage and to develop improved techniques to prevent their further accretion both in the individual and in the community. The first category, modification of the environment, includes such activities as mental health education, community organization and administrative consultation. The second category includes such activities as anticipatory guidance, crisis intervention, and case-centered or consultee-centered agency consultation. The author concludes that in the light of contemporary knowledge about the prevention of emotional disorder, that the miasma model as applied in basic public health concepts, should be the basis of a community mental health practice model. These concepts are: (1) an emphasis on primary prevention rather

than on treatment or rehabilitation (2) an emphasis on the total community rather than the individual; and (3) the importance of working with community agencies toward the goal of improving a community's emotional well-being.

_____. "Prevention of Mental Disorders: Advances in Theory and Practice," *Community Mental Health Journal* 15 (1979): 179-91.

The status of primary prevention is reviewed, beginning with a clarification of basic concepts and definitions. Two general types of interventions to control physical or emotional disorders are highlighted: (1) reducing the prevalence of the conditions, and (2) reducing the severity, discomfort, or disability associated with the condition. Prevalence itself may be reduced using two approaches: reducing the duration of the condition through early case-finding and treatment (secondary prevention), and reducing the incidence of the condition (primary prevention). Such primary prevention efforts may be aimed at an entire population or at only those persons thought to be at excess risk. The author also elaborates on disease prevention and health promotion as dual focuses in primary prevention. The need for a new paradigm in primary prevention is based on the realization that most psychiatric and some medical conditions do not have a single identifiable precondition. Instead, research suggests that it will be more useful to identify stress-producing crisis events, rather than predisposing variables, and to develop social support systems, and individual and collective competences. Application of this paradigm can lead to significant progress in the prevention of emotional disorders of all kinds. Four general issues affect the establishment of such primary prevention programs: (1) the need to view health as a process, rather than an end state, thereby permitting a range of interventions, (2) clarification of the role of the recipient of services in terms of the individual's own efforts to remove barriers to health, (3) determining appropriate levels of intervention, and (4) primary prevention as opposed to direct treatment. The current challenge of primary prevention is to reduce societal, governmental, and professional obstacles and indifference to experimentation and program development. The author suggests that it may be necessary to establish a separate prevention agency to accomplish this.

BLOOM, MARTIN., *Primary Prevention: The Possible Science*, Englewood Cliffs, N.J.: Prentice Hall, 1981.

This text encompasses primary prevention from a wide interdisciplinary perspective. It discusses concerns about definitions; the history of preventive thinking; preventive problem-solving; examplars of primary prevention programs through the early, middle, and later years of the life cycle; paradigms, models, and theories; principles of preventive practice; evaluation; costs and benefits; and barriers and criticisms.

BOWER, ELI., "Primary Prevention of Mental and Emotional Disorders: A Conceptual Framework and Action Possibilities." *American Journal of Orthopsychiatry* 33 (1963): 832-47.

The framework and methodology for primary prevention of mental and emotional disorder presented here is based on the concept of behavioral freedom, which is defined as the ability to develop and maintain a resiliency and flexibility in response to a changing environment and a changing self. When such forces as institutions and services increase the freedom in individual and social behavior, they are labeled as mentally healthy; when those forces reduce freedom, they are unhealthful. Preventive and life-enhancing actions based on these conceptual

premises are suggested for institutions and services to apply in the emotionally hazardous crises that occur within their domains.

The article also describes five sources of resistance to the development of primary prevention programs in the field of mental health: (1) the belief that large-scale societal change is necessary to prevent the emergence of psychosocial problems, (2) the possibility that preventive programs may be viewed as an invasion of personal privacy, (3) the position that less successful, disadvantaged, or disabled persons serve an important function in society and that prevention would therefore be undesirable, (4) the lack of training and interest in primary prevention among mental health professionals, and (5) the problems encountered in defining the goals of prevention.

CAPLAN, GERALD., *Principles of Preventive Psychiatry.* New York: Basic Books, 1964.

The public health model of primary, secondary, and tertiary prevention is presented as a framework for the discussion of theories and concepts of preventive community psychiatry. Special attention is given to the techniques developed in two major area: (1) principles of community planning and methods used to promote preventive community programs, and (2) types and applications of mental health consultation.

COWEN, EMORY L., "Demystifying Primary Prevention." *In Primary Prevention of Psychopathology,* Vol. 2, *Environmental Influences,* ed. Donald G. Forgays, Hanover, N.H.: University Press of New England, 1978.

Mental health professionals are urged to increase their involvement in two important arenas to clarify and operationalize the elusive concepts and principles of primary prevention: (1) the analysis and modification of social environments (community, church, school, and family) with the goal of engineering health promoting environments, and (2) building social and interpersonal competence via problem-solving, question-asking, and goal-setting skills to assure a more adaptive fit between person and environment. Examples of successful programs are provided for each area. The author suggests that further progress in primary prevention will require "new marriages" between mental health professionals and architects, urban planners, and social scientists. New training combinations are envisioned to produce such qualified helping persons.

_____. "Primary Prevention Misunderstood," *Social Policy* 7 (March-April 1977): 20-27.

Efforts to apply principles of primary prevention in the area of mental health reveal a gap between abstract definitions and actual illustrations. Moreover, because of the lack of clear boundaries in the mental health field, virtually any effort to improve the human condition can be viewed as primary prevention. To overcome these difficulties, it is suggested that greater attention be focused on two areas that are conceptually and pragmatically appropriate for primary prevention approaches: These are: (1) the analysis and modification of social environments, and (2) providing training in social competence. The recent literature is reviewed and evaluated for both topics.

_____. "Social and Community Interventions." *Annual Review of Psychology* 24 (1973): 423-72.

A social and community intervention framework is presented as an alternative to the traditional medical model approach, which emphasizes the classification and treatment of psychological disorders. Social and community interventions are

intended to prevent such disorders by engineering primary institutions and social settings that shape the development of the well-being of large numbers of persons. Its key components include analysis and modification of social systems and stress such approaches as early childhood intervention, crisis intervention and consultation. The article illustrates the application of the social and community intervention model to programs in the inner city and in the school system.

FORGAYS, DONALD G., ed., *Primary Prevention of Psychopathology,* Vol. 2, *Environmental Influences.* Hanover, N.H.: University Press of New England, 1978.

This volume consists of the papers presented at the Second Vermont Conference on the Primary Prevention of Psychopathology. The papers described environmental factors contributing to the development of psychopathology and sought to define forms of environmental manipulation that might prevent psychopathology. In addition to papers discussing a conceptual framework for the analysis and modification of the environment, other papers discussed evaluation of environmental approaches to prevention. The appendix is the 1978 report of the Task Panel on Prevention of the President's Commission on Mental Health.

HOLLISTER, WILLIAM G., "Basic Strategies in Designing Primary Prevention Programs." In *Primary Prevention: An Idea Whose Time Has Come,* ed. Donald C. Klein and Stephen E. Goldston. Washington, D.C.: U.S. Government Printing Office, 1977.

Strategies based on the stress model are advocated to help program planners create practical, useful programs of primary prevention. Modest, feasible goals suggested are the prevention of (1) specific behaviors that are self-defeating or harmful to others, (2) role failures, (3) relationship breakdowns, (4) feeling overreactions, and (5) psychological disabilities, such as the deterioration of a confined, ill person. Stimuli become stressors when they threaten survival or emotional security, defeat our expectations, overwhelm our coping abilities. Activities in two major areas of prevention are discussed—clinical prevention with individuals or families, and group-level prevention. A key planning task in group-level prevention is the identification of target groups who are exposed to unusual frequency, duration, intensity, clustering or types of stressors; who may or may not realize they are at risk; who are known from previous experience to have a high degree of risk when under stress; who are accessible; and for whom there is a feasible intervention. Four major strategies of primary prevention are discussed: (1) stress management, which diminishes, modifies, or eliminates the stressors, (2) stress avoidance, which removes individuals at risk from exposure to stressors, (3) stress resistance building, which creates an individual or group capacity to withstand stressors, and (4) stress reaction management, which decreases inappropriate reactions to stressors.

KELLY, JAMES G., "The Quest for Valid Preventive Interventions." In American Psychological Associations, *Issues in Community Psychology and Preventive Mental Health.* New York: Behavioral Publications, 1971.

Three methods of preventive intervention are described, together with recommendations for evaluation procedures and experimental research designs appropriate to each method. The first method is mental health consultation, which focuses on improving the functional competence of the consultee. Such consultation is viewed as preventive when the benefits of professional knowledge are transmitted to large segments of the population. Thus, research approaches to document the effectiveness of consultation efforts must provide for the spreading effects of the inter-

vention. A quasi-experimental time-series design is recommended to evaluate the effectiveness of mental health consultation.

The second method involves organizational change of helping community agencies to enable them to deal more effectively with crises and emergencies. Prevention is thus aided by the development of responsive and flexible organizations. The effectiveness of this method is best measured by using a nonequivalent control group design to observe changes in the adaptive behavior of the organization. The third intervention, community development, has as its primary goal the creation of opportunities for a community to plan its own change and to implement these opportunities, thus mitigating the effects of unexpected social change. To assess the validity of such community development efforts, the recurrent institutional cycle design is recommended as a research methodology. The author advocates that more attention be devoted by research centers to studying the impact of social problems and public issues at the community level.

KLEIN, DONALD C., *Community Dynamics and Mental Health,* New York: John Wiley & Sons, 1968.

Such dynamics as communication, power, change, action, decision making, and linkages between systems are viewed as key concepts in analyzing community needs and in promoting preventive and therapeutic community programs. It is argued that mental health professionals are generally ill-prepared to study community processes because of their orientation to the individual and his psychological functioning.

KLEIN, DONALD C., and GOLDSTON, STEPHEN E., eds., *Primary Prevention: An Idea Whose Time Has Come.* Washington, D.C.: U. S. Government Printing Office, 1977.

This monograph summarizes the proceedings of the Pilot Conference on Primary Prevention held in April 1976 under the auspices of the National Institute of Mental Health and the National Associaton of Mental Health. The collection of papers, including formal presentations and workshop summary statements, represents a state-of-the-art document in the development of theoretical and working strategies in primary prevention. The section on the application of prevention concepts to programming should be helpful to both social work educators and practitioners.

MCPHEETERS, HAROLD. "Primary Prevention and Health Promotion in Mental Health," *Preventive Medicine* 5 (1976): 187-98.

An innovative, conceptual, diagrammatic model for the primary prevention of emotional disorders and the promotion of positive mental health is discussed. The model views primary prevention and health promotion as comprising the general field of prevention, with primary prevention aimed at specific populations at risk or under stress, and promotion efforts aimed at the general well-functioning public. Both approaches require strategies directed toward people and the environment, and numerous examples are provided of each. The author emphasizes that the targets and strategies for both approaches must be clearly identified so as to avoid the ambiguities found in most prevention and promotion efforts. To achieve this clear statement of the problem and the intended solution, guidelines are provided for (1) assessing the needs of the population, (2) setting objectives and criteria for success, and (3) evaluating efforts.

MUNOZ, RICARDO. "The Primary Prevention of Psychological Problems: A Review of the Literature." *Community Mental Health Review* 1 (1976): 1-15.

This article is a comprehensive review of the multidisciplinary literature of primary prevention. It offers evidence to counter the skepticism of those who view primary prevention programs as far-fetched or well-meaning but ineffective social interventions. Several successful research programs are presented. The four most common prevention approaches identified from the literature are (1) the developmental-life cycle approach, (2) the functional areas approach, (3) the the specific disorders approach, and (4) the specific population approach.

PERLMUTTER, FELICE, VAYDA, ANDREA M., and WOODBURN, PAUL V. "An Instrument for Differentiating Programs in Prevention—Primary, Secondary and Tertiary." *American Journal of Orthopsychiatry* 46 July 1976: 533-41.

The article describes the development and use of a rating instrument for differentiating mental health programs in terms of Caplan's three definitions of prevention at the primary, secondary, and tertiary levels. A major cause of the slow development of preventive programs is related to inadequate understanding of these three levels, which are best viewed as overlapping categories on a continuum, rather than as distinct categories. The parameters for analyzing which level of prevention is dominant are (1) the target population, (2) the beneficiary of the program, and (3) the intended goals of the program.

Task Panel on Prevention, Commission on Mental Health. *Report to the President*. Vol. 4. Washington, D.C., 1978. Superintendent of Documents.

The report begins with the conviction that society must be measured by the steps it takes to prevent every form of preventable misfortune. The development of primary prevention programs is viewed as the great unmet need of our times and as the "fourth revolution" in mental health. Primary prevention is directed toward populations not yet affected by individual breakdown. It is defined as an attempt to lower the incidence of mental disorder by (1) reducing environmental stresses through social engineering, and (2) promoting personal competence and coping skills through education for populations at risk. The report takes the position that a simple cause-and-effect or medical model approach is ineffective and that a multicausal framework is necessary to preventive efforts. Areas in which research has proved the promise of primary prevention are elaborated, including competency training emphasizing developmental approaches, the modification of social systems, influencing individual development, and the reduction and management of naturally occurring life development stresses. Six fully elaborated recommendations cover the necessary organizational structures, program priorities and emphases, funding mechanisms, and monitoring efforts for prevention: (1) a coordinated national effort including grants, training, and research in, a Center for Primary Prevention at the National Institute of Mental Health, and primary prevention offices in the Public Health Service regions and at the state and local levels, (2) a legislative mandate and executive order to all relevant government agencies to develop preventive programs, (3) a top priority designation for program development, training, and research related to infants, young children, and their environments, (4) a strengthened national concern to reduce societal stresses produced by racism, poverty, sexism, ageism, and urban blight, (5) substantially increased funding, and (6) a ten-year mandate for the proposed federal program.

SOCIAL WORK AND PRIMARY PREVENTION

BLOOM, MARTIN. *Life Span Development: Bases for Preventive and Interventive Helping.* New York: Macmillan, 1980.

This book is intended as a text in preventive intervention for the human behavior and social environment curriculum in social work education. Its broad range of readings covers content about the implications of age groupings, sex gender, ethnicity, and social classes; a view of life development involving multiple generations and events; and accounts of preventive efforts that complement the book's empirical and theoretical presentations.

Part 1 provides an overview and table of physical, psychological, and social factors involved in human growth and development. Part 2 traces the developmental stages, tasks, and challenges that occur in the life cycle and offers examples of helping interventions; attention is given to the life span of minority persons and persons with varied cultural backgrounds. Part 3 explores preventive and interventive actions for special populations, such as women, minorities, and migrant workers. Part 4 offers a section on how to read statistical tables and emphasizes the need to understand phenomena affecting total populations; the tables selected as teaching examples include statistics on marriage, birth, death, education, and work, and are intended to be those more useful for "applied social scientists who seek to obtain a grasp of social events and trends."

GEISMAR, LUDWIG L. and KRISBERG, JANE. "The Family Life Improvement Project: An Experiment in Preventive Intervention. *Social Casework* Part 1, 17 (1966): 563-570 and Part 2, 17 (1966): 663-667.

This two-part paper describes the Family Life Improvement Project sponsored by the Rutgers University School of Social Work. The Project used an experimental panel design of five hundred families with two control groups to determine whether providing social work services to young urban families could prevent social malfunctioning and disorganization of the family over a five-year period. The treatment group received a variety of services including referral, job-finding, and marriage counseling; the control groups were monitored but received no services.

The design of the study is based on three concepts: (1) that family functioning becomes more problematic as the family moves through the life cycle, (2) that early intervention reduces later malfunctioning and can therefore be viewed as preventive, and (3) that empirical analysis of the functioning of young families can provide practice suggestions and direction. The authors address the "when" and "how" of prevention implicit in this design. The timing of early preventive intervention is based on family research which suggests that disorders increase as families grow older. The actual treatment plan addresses the various needs and problems of the families. This is accomplished by categorizing the family into four groups, specifying the level of functioning, and matching appropriate interventions.

In analyzing the problem families, the authors found that the most common denominator was deficient communication and the inability of family members to relate to each other emotionally, intellectually, and sexually. Social work services were directed toward helping the families cope with anticipated malfunctioning,

rather than toward existing problems. To achieve this, the caseworker fulfilled several roles--counselor, mediator, enabler, broker, and advocate. Clients were helped to examine possible solutions and to improve their problem-solving abilities and their skills in dealing with community agencies. It was felt that by bringing community services or even the knowledge of community resources to families before breakdown, intervention became truly preventive.

Further findings are noted on three of the four categories of families requiring service. The near-adequate group faces minor crises usually in family relationships and are generally able to recover using the family's own strength and resources; limited professional help may include information, advice, and some counseling. Near-problematic families experience interpersonal and economic difficulties; more intensive counseling and the provision of resources such as job training and better housing may be necessary. Finally, problematic families live with potentially dangerous situations, including substandard housing, improper infant care, and major psychiatric illness. Economic, social and emotional support is crucial for such families.

KAHN, ALFRED J. "New Policies and Service Models: The Next Phase." *American Journal of Orthopsychiatry* 35 (1965): 652-62.

The concept of social utilities is developed and elaborated as part of the institutional perspective toward social welfare. Social utilities are defined as those facilities and resources that society should routinely provide to enhance the quality of life, rather than to remedy dysfunctioning. Some applications of the concept of social utilities for children are: (1) beginners day school and school lunches; (2) home helps and "park aunts" for mothers who may need a place to leave their children for a few hours; (3) family and child vacations; (4) information and advice bureaus, which also have the potential for becoming a center for case-finding and referral. The author concludes that case services can only be soundly utilized in a framework of provision for (1) adequate income maintenance, health and housing and (2) adequate social utilities which are basic to urban industrial life.

_____. "Therapy, Prevention and Developmental Provision: A Social Work Strategy." *Public Health Concepts in Social Work Education,* New York: Council on Social Work Education, 1962.

The author recognizes the major role of social work at all three preventive levels of the public health model and urges that social work consider developmental provision as a unique role beyond these levels. Developmental provision relates to needs evolving from a complex industrial society and includes the right to services by virtue of membership in the society. Social work should avoid anchoring the concept of developmental provisions to the prevention or eradication of pathology.

MEYER, CAROL H. "Preventive Intervention: A Goal in Search of a Method." In *Preventive Intervention in Social Work,* ed. Carol H. Meyer. Washington, D.C.: National Association of Social Workers, 1974.

The concept of preventive intervention involves a new perspective in social work practice requiring new concepts, methodologies, and techniques. The article is a lead paper to a collection of reprints from the National Association of Social Workers' journal *Social Work*. The collection was designed to illustrate interventions that take into account the interaction of the client and the environment

rather than simply focus on a clinical judgment of the individual. The broader arena enables the practitioner to seek effective points for interventions to restore a balance between the person and the environment and to enhance the coping strengths of the client. The enlarged context offers opportunities for preventive intervention.

PERLMUTTER, FELICE. "Prevention and Treatment: A Strategy for Survival." *Community Mental Health Journal* 3 (1974): 276-81.

To be effective, the author argues, preventive efforts in community mental health centers need to be structurally segregated from treatment services, and social agencies in the voluntary sector should assume a leadership position in developing such preventive programs. The following justifications are offered for these positions: (1) the federal mandate to combine treatment and prevention has not been fulfilled as evidenced by the surveyed lack of prevention activities, (2) the dual objectives of prevention and treatment are fundamentally incompatible because of inherent ideological and organizational conflicts, (3) the government financing design, which emphasizes reimbursable unit costs, virtually eliminates funding for prevention activities, and (4) the history of voluntary social work agencies in the United States in working with a continuum of service delivery from treatment to social movements has provided them with an expertise which should not be neglected in the development of community mental health programs.

RAPOPORT, LYDIA. "The Concept of Prevention in Social Work." *Social Work* 6 (1961): 3-12.

The distorted application of the public health model of prevention to social work practice presents the danger that all social work activities could be called prevention, thus diluting the preventive function. It is suggested that prevention be more sharply defined, which would give impetus to the development of primary prevention activities. Two phases of primary prevention are discussed. The first, health promotion, includes anticipatory guidance, emotional immunization, and efforts to strengthen individuals to deal with specific life tasks and face both anticipated and unanticipated crises. The second phase, specific protection, includes efforts directed at a specific population determined to be at risk.

REINHERZ, HELEN. "Primary Prevention in Community Mental Health: Holy Grail or Empty Vessel." In *Community Mental Health: Issues for Social Work Practice and Education*, ed. Arthur J. Katz, New York: Council on Social Work Education, 1979.

A comprehensive overview of the development of the concept of primary prevention is presented, emphasizing the relationship of primary prevention to social work theory and practice, highlighting the contributions of social workers to the concept, and identifying the prevention skills and programs of social work. The conclusion of this overview is that primary prevention has provided sufficient evidence of hope and promise to warrant its inclusion in social work education and practice in the field of community mental health.

WITTMAN, MILTON. "Application of Knowledge about Prevention in Social Work Education and Practice." *Social Work in Health Care* 3 (1977): 37-47.

This article reviews the status of preventive social work practice and education in the United States and examines the contributions of public health, mental health,

and social work to the knowledge of prevention. Some of the contributions from public health are maternal and child health services, gerontological care, multiphasic and screening services, long-term care, identification of health hazards, life cycle courses, health education, diet and weight control programs, health policies, and the structuring and coordination of health services. From mental health comes a mix of behavioral science and community organization interventions, such as parent effectiveness and teacher training, widow-to-widow programs, suicide prevention, rape counseling, geriatric mental health planning and consultation, and self-help initiatives. Social work contributed the combination of both micro and macro perspectives and preventive interventions to strengthen family life through maternal and child health programs. Cited are Rapoport's three aspects of social work intervention— (a) timely intervention in family problems, (b) coordinated services, and (c) legislative and regulation reforms aimed at preserving personal and family integrity.

The author then discusses the inclusion of preventive content in social work education and practice, mentioning such approaches as natural helping networks, social epidemiology, community development, and anticipatory guidance as part of crisis intervention, suicide intervention, self-help groups, family life education, and parent and teacher education.

_____. "Preventive Social Work." In *Encyclopedia of Social Work*, 17th ed. Washington, D.C.: National Association of Social Workers, 1977.

Although the concept of preventive social work is neither well developed in theory nor systematically tested and validated in practice, several emerging themes can be identified: (1) recognition of the importance of strengthening natural helping systems, (2) reaffirmation of the importance of infancy and childhood as focuses for intervention, (3) recognition of crisis intervention as an entry point for services that can be crucial to future well-being, and (4) the recognition that interventions must be interdisciplinary and utilize a number of approaches if services are to be truly preventive. The allocation of additional resources to prevention research is seen as critical to the development of successful preventive efforts.

PREVENTION PROGRAMS

BARD, MORTON, and ZACKER, JOSEPH. "The Prevention of Family Violence: Dilemmas of Community Intervention." *Journal of Marriage and the Family* 33 (1971): 677-82.

This article describes a demonstration project and field experiment involving police crisis intervention to prevent acts of violence among family members. The authors trained specially selected and motivated policemen for family crisis intervention by using real-life situations and specially written plays depicting family crises. The solutions to each situation were not provided and officers learned to anticipate a variety of outcomes and to develop their own strategies. Compared to the matched control precinct, the precinct with the trained officers showed fewer total family disturbances, fewer recurrences of violence in the same family, and fewer homicides and assaults involving family members and responding officers. These successes are attributed to the development of police interpersonal skills

that constructively affected deteriorating family situations. The preventive aspects of this project are emphasized as contrasted to the traditional ex post facto responses of the law and psychiatry. Social agencies, too, are considered ineffective because of their middle-class orientations, regular business hours, and physical distance from violent neighborhoods. Although this project was viewed as an unquestionable success, it was noted that certain moral, ethical, and legal dilemmas accompany such innovative approaches. The most significant of these occurs, when a violent outcome has been predicted, but no action can be taken without violating individual civil rights.

BROUSSARD, ELSIE R. "Primary Prevention Program for Newborn Infants at High Risk for Emotional Disorder." In *Primary Prevention: An Idea Whose Time Has Come*, ed. Donald C. Klein and Stephen E. Goldston. Washington, D.C.: U.S. Government Printing Office, 1977.

This article describes the author's Pittsburg First-Born Preventive Intervention Program. The author demonstrated in a longitudinal study that an intervention program could modify the mother's negative perception of her infant and could have significant impact on increasing the child's optimal development as compared to a low-risk group. High-risk infants were identified through administering the Neonatal Perception Inventory, an instrument which was designed to measure the perceptions of mothers toward their infants during the first month of life. The mother's perception of the infant during the first month was associated with the child's later development. Mothers of infants judged to be at high risk for emotional disorder were entered in a program that utilized the specific technique of supplementary parenting through mother-infant group meetings and home visitations. Another significant finding was that an intervention program, such as the televised guidance used by the author, could have a significant impact on the subsequent development of the child.

DAVIS, DAVE H. "SIDS: An Opportunity for Primary Prevention." *American Journal of Psychiatry* 132 (1975): 648-49.

Crisis intervention services to families in which a sudden infant death (SIDS) has occurred are a means of preventing subsequent family disruption and psychiatric illness among parents and siblings. Primary prevention activities in SIDS also includes providing information about the nature of the disease, the rapid performance of an autopsy, and discussion of findings with the family.

GOLDSTON, STEPHEN E. "An Overview of Primary Prevention Programming." In *Primary Prevention: An Idea Whose Time Has Come*, ed. Donald C. Klein and Stephen E. Goldston. Washington, D.C.: U.S. Government Printing Office, 1977.

The present "state of the art of primary prevention" is outlined. The basic principles and practices of primary prevention emerge from the ideology of community mental health and include (1) a commitment to raising the level of mental health of the entire community, (2) involvement in community care-giving systems and awareness of their role in the mental health of the community, and (3) the relevance of public health concepts and practices, such as populations at risk, incidence rates, and epidemiological techniques and analyses. Four frameworks for conceptualizing primary prevention efforts are described: (1) primary prevention of the mental illnesses of known etiology, (2) primary prevention of the mental illnesses of unknown etiology, (3) primary prevention of emotional distress, maladaption, maladjustment, needless psychopathology, and human misery, and (4) promotion of mental health. The overall objectives of primary prevention are seen as reducing the incidence of

new instances of emotional distress and promoting emotional well-being. Suggested strategies are twofold--first, strengthening individual capacities or decreasing individual vulnerabilities, and second, modifying the environment through planned social change. Assets, barriers, and forces related to the emergence of primary prevention as a respectable mental health activity are summarized. A program for the parents and siblings of victims of Sudden Infant Death Syndrome is described as a model for program development, and several principles for program development are described. A number of unmet needs are discussed, including (1) the need for a commitment to prevention efforts at the policy level, (2) sufficient financing, (3) expansion of the knowledge base through new research, (4) providing inservice training for mental health workers in public health principles, (5) developing training programs in primary prevention content, techniques, and methods, and (6) creating a clearinghouse of information on ongoing primary prevention projects.

HARTLEY, WYNONA S. "Preventative Outcomes of Affective Education with School Age Children: An Epidemiologic Follow-up of the Kansas City School Behavior Project." In *Primary Prevention in Mental Health: An Idea Whose Time Has Come*, ed. Donald C. Klein and Stephen E. Goldston. Washington, D.C.: U.S. Government Printing Office, 1977.

The article describes the effectiveness of small group multidisciplinary training for sixth grade teachers participating in the Kansas City School Behavior Project to develop techniques for preventing severe behavioral disturbances among adolescents. The central themes of the training program were the exploration of feelings, the use of small groups as a vehicle for social and academic motivation, and the recognition of and dealing with social system and social class differences. The major recommendation was that mental health small group techniques be instituted in the classroom.

HEBER, F. RICK. "Sociocultural Mental Retardation: A Longitudinal Study." In *Primary Prevention of Psychopathology*, ed. Donald G. Forgays. Vol. 2, *Environmental Influences*. Hanover, N.H.: University Press of New England, 1978.

The paper describes a five-year research and intervention project on the prevention of cultural-familial mental retardation, which is mental retardation that exists in the absence of demonstrable pathology of the central nervous system. The goal of the project was to test the hypothesis that social deprivation was involved in the etiology by attempting to prevent mental retardation in the offspring of retarded mothers, a high-risk group. Families in the experimental group received an intensive rehabilitation program with two emphases: (1) a maternal program consisting of educational activities, vocational rehabilitation, and homemaking and child-care training for the mother, (2) an infant program that consisted of an intense, personalized program focusing on language, cognitive, and perceptual-motor skills. Differences between the experimental and matched control group were measured in areas of infant health, intelligence, language development, and mother-child interaction; the mothers' vocational adjustment and general social functioning were also measured. The maternal program produced significant changes in the mother's attitude and behavior with her children, and the most effective component of the program was the superior job stability and work performance of mothers in the experimental group. The infants in the experimental program showed superior skill in language development and in the learning and performance of tasks, and they had higher overall intelligence scores. Furthermore, the experimental children were better prepared to enter school, and unlike the controls, none of them scored in the retarded range. Notably these differences in intelligence quotients persisted three years after school entry. The findings indicated that this form of mental retardation may be preventable.

HOLLISTER, WILLIAM G. "Basic Strategies in Designing Primary Prevention Programs." In *Primary Prevention: An Idea Whose Time Has Come*, ed. Donald C. Klein and Stephen E. Goldston. Washington, D.C.: U.S. Government Printing Office, 1977.

Strategies based on the stress model are advocated to help program planners create practical, useful programs of primary prevention. Modest, feasible goals are the prevention of (1) specific behaviors that are self-defeating or harmful to others, (2) role failures, (3) relationship breakdowns, (4) feeling overreactions, and (5) psychological disabilities, such as the deterioration of a confined, ill person. Stimuli become stressors when they threaten survival or emotional security, defeat our expectations, or overwhelm our coping abilities. Activities in two major areas of prevention are discussed—clinical prevention with individuals or families, and group-level prevention. A key planning task in group-level prevention is the identification of target groups who are exposed to unusual frequency, duration, intensity, clustering or types of stressors; who may or may not realize they are at risk; who are known from previous experience to have a high degree of risk when under stress; who are accessible; and for whom there is a feasible intervention. Four major strategies of primary prevention are discussed: (1) stress management, which diminishes, modifies, or eliminates the stressors, (2) stress avoidance, which removes individuals at risk from exposure to stressors, (3) stress resistance building, which creates an individual or group capacity to withstand stressors, and (4) stress reaction management, which decreases inappropriate reactions to stressors.

_____. "The Management of Primary Prevention Programs." In *Primary Prevention: An Idea Whose Time Has Come*, ed. Donald C. Klein and Stephen E. Goldston. Washington, D.C.: U.S. Government Printing Office, 1977.

A systems analysis approach is suggested to outline and define the work involved in setting up, operating, monitoring, evaluating, and maintaining a primary prevention program in a local community mental health center: (a) assessment and verification of needs, (b) establishment of sanction to plan and develop, (c) implementation planning, (d) design and implementation of feasibility trials of each prevention project, (e) establishment of the staff organization necessary to the program, (f) final presentation of the total program to obtain a mandate, (g) selection and hiring of new staff, and (h) setting up management and operation processes.

KLEIN, NANCI C., ALEXANDER, JAMES F., and PARSONS, BRUCE V. "Impact of Family Systems Intervention on Recidivism and Sibling Delinquency: A Model of Primary Prevention and Program Evaluation," *Journal of Consulting and Clinical Psychology* 45 (1977): 469-74.

This study utilizes an innovative multilevel intervention and evaluation model to determine the effectiveness of a family systems approach to the prevention and treatment of juvenile delinquency. After demonstrating that short-term, behaviorally-oriented family treatment had a positive effect on maladaptive family interaction (tertiary level) and delinquency recidivism (secondary level), the study reported a substantially reduced delinquency rate among siblings in the target families (primary level). In addition, this behavioral systems approach was more effective and showed greater maintenance of improvement than the comparison client-centered family group therapy. Preventive approaches were concluded to be highly consistent with a systems orientation to psychopathology. Thus, the reduction in current delinquent episodes and the prevention of such behavior in siblings was attributed to the therapeutic impact on the entire family system, not just the individual with problems. The study attests to the family as a highly potent socialization force and as a principal target for prevention programs.

PRICE, RICHARD H., KETTERER, RICHARD F., BADER, BARBARA C., and MONAHAN, JOHN, eds. *Prevention in Mental Health: Research, Policy and Practice*. Beverly Hills, Calif.: Sage Publications, 1980.

This volume of fifteen articles focuses on prevention activities related not to the traditional concern with the psychological well-being of individuals, but rather to mediating structures of society, which includes neighborhoods, families' workshop systems, churches, self-help groups and voluntary associations. The first four chapters are problem focused and cover economic change, domestic violence, child abuse and neglect, and divorce. The next four chapters are concerned with the settings and social environments that provide both the context and the opportunity for prevention programs in schools, delinquency programs, industrial settings and social networks. The remaining chapters cover state and federal perspectives on prevention, strategies and skills for promoting mental health, and guidelines for evaluation.

RABER, MERRILL F. "Involvement of the Community in Primary Prevention." In *Primary Prevention: An Idea Whose Time Has Come*, ed. Donald C. Klein and Stephen E. Goldston, Washington, D.C.: U.S. Government Printing Office, 1977.

A number of approaches are described that can be used by a community mental health center to involve the community in defining its mental health needs and in developing strategies which will have an impact on the environment and help reduce the risk of disorder throughout the entire community. Included are community resource councils, teacher training programs, family life education programs, visiting nurse programs, counseling seminars, child services coordinators, employee assistance programs, socialization groups, drop-in centers, and worry clinics.

REINHERZ, HELEN and GRIFFIN, CAROL L. "Identifying Children at Risk: A First Step to Prevention." *Health Education* 8 (1977): 14-16.

The article describes a preschool screening program designed to identify potentially vulnerable children who might be at risk with physical, sensory, motor, perceptual, cognitive, language, social, or emotional difficulties, and who require additional evaluation. The goal of the program was to prevent the continuation of maladaptive behavior before a pattern of repeated failure was established with the resultant loss of confidence and self-esteem. A procedure for long-term monitoring of children who are designated as potentially at risk is described.

SANTOS, ROBERT R. "Developing Primary Prevention Programs with Major Community Institutions," In *Primary Prevention: An Idea Whose Time Has Come*, ed. Donald C. Klein and Stephen E. Goldston. Washington, D.C.: U.S. Government Printing Office, 1977.

This paper describes a primary prevention social work program for children entering school. The program began as a collaborative effort between a public school system and a community mental health center and was eventually fully incorporated into the school system. School administrators, teaching staff, parents, and community mental health center staff combined their resources to provide a program for parents and teachers that would ease the child's and parents' separation process and establish an open network of communication that would help avoid future difficulties in the child's classroom adjustment.

SPIVACK, GEORGE, and SHURE, MYRNA B. "Preventively Oriented Cognitive Education of Preschoolers," In *Primary Prevention: An Idea Whose Time Has Come*, ed. Donald C. Klein and Stephen C. Goldston. Washington, D.C.: U.S. Government Printing Office, 1977.

This article describes the preventive implications of a program that teaches interpersonal cognitive problem-solving skills to preschoolers. Since well-adjusted children are better problem-solvers, the program attempted to improve the child's adjustment not by modifying his behavior, but by enhancing his style of thinking in solving interpersonal problems. More trained than nontrained youngsters were normally adjusted throughout the nursery year and maintained that adjustment throughout kindergarten and first grade.

SOCIAL COMPETENCE

BOND, LYNNE A., and ROSEN, JAMES C., eds. *Competence and Coping during Adulthood.* Vol. 4. Hanover, N.H.: University Press of New England, 1980.

This volume consists of the papers presented at the fourth Vermont Conference on the Primary Prevention of Psychopathology, which considered issues of competency and coping during adulthood. The text presents a conceptual framework for models of competency and papers covering life satisfaction and life stress during adulthood, the role of work in competence and life satisfaction, and issues of coping and competence in the family unit.

CAMPBELL, ANGUS. "Subjective Measures of Well-Being," *American Psychologist* 31 (1976): 117-24.

Several approaches toward assessing the quality of life are evaluated. The conclusion is that subjective measure of happiness, satisfaction, and freedom from stress add vital dimensions to the widely used objective indicators of well-being in the society, such as the gross national product, educational level, and rate of unemployment.

COTTRELL, LEONARD, JR. "The Competent Community," In *New Perspectives on the American Community*, ed. Roland L. Warren. Chicago: Rand McNally & Co., 1977.

Community competence is defined in terms of four problem-solving skills: (1) the ability to collaborate effectively in identifying community needs and problems, (2) the ability to achieve a working consensus on goals and priorities, (3) the ability to agree on ways and means to implement agreed on goals, and (4) the ability to collaborate effectively in the required actions.

Conditions necessary for competent community functioning are described. A prerequisite condition is a commitment to the community as a valued relationship. Such commitment occurs when people recognize the reciprocal impact of community and person. Good communication is based on effective channels of expression, enabling each segment of the community to articulate its views, needs, and intentions. Formal and informal rules and procedures can be helpful in facilitating interaction and decision making. Also, clear definitions of situations as well as a repertoire of inventive and versatile approaches are needed to contain and accommodate conflict. Lastly, although the larger social context may pose problems with which the community cannot cope, the competent community makes the best possible adaptation to those forces and issues. This occurs by means of continuous planning to meet changing needs and by making full use of specialists to provide expertise for problem-solving.

Community competence was concluded to have two major implications for the field

of mental health. First, the general level of competence of a community can condition the mental health of its population, preventing and combating depersonalization and dehumanization. Second, competence could become the focus and goal of mental health policies, programs, and practices.

FOOTE, NELSON, and COTTRELL, LEONARD, S. JR. *Identity and Interpersonal Competence*, Chicago: University of Chicago Press, 1955.

The development of interpersonal competence in family members can be a powerful force to prevent family and personal disorganization. Such competence is characterized by the capacity to formulate and implement plans in a changing world. Six components of interpersonal competence are identified: (1) health, (2) intelligence, (3) empathy, (4) autonomy, (5) judgment, and (6) creativity. Research hypotheses to study interpersonal family competence are developed, (1) to strengthen positive family functioning and (2) enable family agencies to achieve greater responsiveness.

INKELES, ALEX. "Social Structure and the Socialization of Competence," *Harvard Educational Review* 36 (1966): 265-83.

Competence, the ability to attain and effectively perform valued social roles, is based on a series of qualities that are developed in the socialization process. The social structure may promote the achievement of competence by making available opportunities for learning and mastery, or it may prevent the development of competent functioning by depriving disadvantaged groups of such experiences.

A model of personality is formulated with implications for research on the socialization of competence. This model is composed of five systems: psychomotor, ideational, motivational, relationship, and the self-system. Several components of these systems that contribute to competence are reviewed. Aptitude is described as an innate and potential capacity to excel in specific difficult acts, and a skill is viewed as an aptitude that has been developed in accord with some cultural pattern ("socialized aptitude"). Three cognitive elements of personality, which also influence competence, are discussed: information is considered in terms of its level and quantity; motivation affects the acquisition of such information; and the cognitive style, which takes such forms as concrete, slow, quick, or diffuse thinking, is an important factor in an individual's coping with the demands of society.

The conclusion reached is that a better understanding of competence will be achieved when socialization research expands to focus on observed differences in adult psychosocial functioning, rather than studying primarily the child-rearing process.

JAHODA, MARIE. *Current Concepts of Positive Mental Health-Joint Commission on Mental Illness and Health.* New York: Basic Books, 1958.

This book discusses definitions of mental health that are useful for both research and application. Proposed are six major categories that may serve as appropriate criteria of positive mental health: (1) attitudes of the individual toward himself or herself, (2) the style and degree of growth and self-actualization, (3) the integration of various personality forces, (4) the degree of autonomous functioning, (5) the adequacy of the individual's perception of reality, and (6) environmental mastery.

KENT, MARTHA WHALEN and ROLF, JON E., eds. *Primary Prevention of Psychopathology.* Vol. 3, *Social Competence in Children.* Hanover, N.H.: University Press of New England, 1979.

This volume consists of the papers presented at the Third Vermont Conference on

Primary Prevention of Psychopathology, whose major theme was the examination of competence and coping skills in children. The papers cover such issues as "The Role of Social Competence in Human Adjustment," "Social and Biological Bases of Social Competence," "The Role of Peer Relations in the Development of Social Competence," "Training Social Problem-Solving Skills," and "The Future of Social Competence in a Pluralistic and Changing Society."

PHILLIPS, LESLIE. "The Competence Criterion for Mental Health," *Community Mental Health Journal* 3 (Spring 1967): 73-76.

Two criteria for measuring the success of mental health programs are compared. The criterion of competence--the degree to which the person learns effective coping skills--is viewed as more objective, quantifiable, and relevant to public programming than the criterion of therapeutic effectiveness, which tends to focus on changes in a presumed pathological process.

RAE-GRANT, QUENTIN, A.F., GLADWIN, THOMAS and BOWER, ELI M.: "Mental Health, Social Competence and the War on Poverty," *American Journal of Orthopsychiatry* 36 (1966): 652-64.

The war on poverty is viewed as a major opportunity for prevention in mental health because of its shift in focus from the intrapsychic conflicts of a select few to the development of social competence in the general population. The strategy of promoting social competence is based on an educational model emphasizing the "3 S's" Stresses, Skills, and Supports as factors in evaluation and intervention. The authors speculate that this new approach will eventually "dethrone" psychotherapy as renewed interest develops in community organization and social dynamics. To accomplish this, the training of mental health professionals requires additional input from sociology, anthropology, economics, and political science.

SMITH, M. BREWSTER. "Competence and Adaptation," *American Journal of Occupational Therapy* 28 (January 1974): 11-15.

Competence is viewed as the ability to deal actively and successfully with life challenges. This quality is anchored in the dual attributes of self-respect and hopefulness, and serves as an important component of adaptation. Professionals can be more helpful to their clients by developing the clients' competence rather than by concentrating on their deficits. Several broad therapeutic strategies suggested for developing competence are (1) respectful, careful listening to the client, (2) sustaining faith in the client's potential for change and improvement, (3) assigning properly paced developmental tasks to promote mastery, and (4) exposing the client to appropriate role models.

WHITE, ROBERT W. "Motivation Reconsidered: The Concept of Competence," *Psychological Review* 66 (1959): 296-333.

Competence is defined, in both animals and humans, as the organism's ability to interact effectively with animate and inanimate environments. The motivation to achieve competence cannot be attributed to basic instinctual drives, since these traditional drive theories in animal psychology and psychoanalytic theory have been discredited by experimental research. In both areas of study, behavior patterns of motor activity, mastery of stress, the need for novelty and excitement, and exploring and manipulating the physical environment seem unrelated to the biologically-rooted concept of drive. Rather, these behaviors appear to be directed towards producing effects on the environment, irrespective of any organic need. It is

concluded that motivation for competence is based upon "effectance," a need to have an impact on one's environment. A sense of "efficacy," or competence, is instilled by the achievement of mastery of the environment.

SOCIAL SUPPORT SYSTEMS, NATURAL HELPING NETWORKS, AND SELF-HELP GROUPS

BIEGEL, DAVID and NAPARSTEK, ARTHUR eds. *Community Support Systems and Mental Health: Research, Practice and Policy*. New York: Springer Publishing Company, 1981.

This volume highlights the important roles community support systems can play in prevention, treatment, and rehabilitation programs in mental health. A comprehensive overview of community support systems that crosscuts various types of support systems and population groups is provided by a multidisciplinary group of researchers and practitioners. The book is organized into four parts. Part 1 discusses theory and research about community support systems, including social support, work support, the neighborhood as a support system, primary prevention, and mutual help. Part 2 presents examples of programmatic interventions that provide an overview of existing practice with support systems; these chapters focus on support systems in the black community, natural helpers, religious support systems, and systems for the aged and the chronically mentally ill. Part 3 discusses professional roles with support systems from both conceptual and practice perspectives; chapters focus on professional collaboration with self-help systems and on the professional as consultant. The final section discusses the policy implications of community support systems and presents recommendations for enhanced public policy in this area.

CAPLAN, GERALD. *Support Systems and Community Mental Health: Lectures in Concept Development*. New York: Behavioral Publications, 1974.

This collection of lectures presents the author's twenty-year evolution of theoretical, research and practice efforts in community mental health. Special emphasis is given to the author's most recent conceptual model, the support system, which consists of those health-promoting forces at the person-to-person and social levels that enable people to master the challenges and strains of their lives. As one of several models developed by the author to prevent and control mental disorder in the general population, the support system concept is intended to complement and enrich previous approaches, rather than to replace them. In this regard, the author calls for the differential clinical use of a variety of models.

Several of the lectures are directed towards specific professional groups. Psychiatrists are urged to adopt a community activist and government consultant role to implement public health interventions in community mental health programs. Nurses are advised to add a mental hygiene component to their regular functions. Thus, for the pregnant woman, the nurse provides anticipatory guidance and crisis intervention in an attempt to prevent or undo distortions in the mother's relationship to her future infant. Social workers are asked to actualize an ecological and systems perspective in mental health by giving greater attention to the client's environment and by maintaining a dual focus on the needs of the individual and the entire population. Utilization of the family physician as part of the family's support network during times of crisis is also advocated. Other lectures are: an analysis of the impact that educators and the school system have on the

development of the child's personality; and an overview of conceptual models in community mental health; a comprehensive program model for the prevention of mental disorders which includes long-term services when appropriate, use of the crisis intervention approach, focusing on populations at risk, and promoting mutual help groups; and a formulation for detecting the early stages of emotional disturbance of children in problem families.

CAPLAN, GERALD and KILLILEA, MARIE, eds. *Support Systems and Mutual Help*. New York: Grune & Stratton, 1976.

This book is partly a progress report on the theoretical and practical explorations of the support systems model being developed at the Laboratory of Community Psychiatry at Harvard Medical School. The aim of the Harvard project is to use research findings and practice principles in the development of a coherent community mental health framework; program planning and the application of clinical techniques would then take place within this framework.

The book consists of three parts. The first section of five theoretical chapters focuses on concepts of support systems and mutuality, exploring mutuality and reciprocity in the family support system, the interface between religion and mutual support processes, and the significance of confession and public testimony as processes in mutual helping. The hypothesis is that there is a developmental progression wherein individuals and groups move from private to public to political domains in resolving distress. A position paper on self-help treatment programs traces the sociopolitical forces behind the self-help movement and concludes that many of these new developments attest to a consumer rebellion. An exhaustive review of mutual help organizations is provided.

Each chapter in the second section describes an empirical study of a society or an organization as it relates to support systems. One chapter provides a textual analysis of eighteenth century English literature in an effort to highlight dominant values, attitudes, practices, and especially systems of psychology. Other chapters focus on the organizational and therapeutic dynamics of Parents Without Partners and Recovery, Incorporated.

The articles in the third section are the attempts of the Harvard group to devise intervention techniques and strategies based on support systems and mutual help. One paper outlines an educational seminar and discussion group devised to help adults separated from their spouses. In the same chapter, the concept of transition states-extended periods of change, and role adaptation following the immediate crisis period-is explicated, and three kinds of helpers are identified as necessary to provide supportive programs for persons in transition: the expert, the veteran, and the fellow participant. Two papers deal with programs for widows, with emphases given to the complex role of the professional vis-a-vis the self-help group and to the range of helping styles offered by widow-counselors. Another effort discussed is a peer consultation program for members of the clergy. The last chapter presents support system interventions in Israel during the 1973 Yom Kippur War.

COLLINS, ALICE. "Natural Delivery Systems: Accessible Sources of Power for Mental Mental Health," *American Journal of Orthopsychiatry* 43 (1973): 46-51.

Mental health consultation is advocated for "natural neighbors," key community persons who view themselves, and are viewed by others, as having a caring attitude as well as access to resources of information and influence. These individuals represent a major untapped preventive resource in mental health, and consultee-

centered consultation to such persons would greatly enlarge the number of families benefitting from mental health concepts.

COLLINS, ALICE and PANCOAST, DIANE L. *Natural Helping Networks: A Strategy for Prevention.* Washington, D.C.: National Association of Social Workers, 1976.

In the course of a demonstration research project to initiate an information and referral exchange for family day care, small informal neighborhood networks meeting social service needs were uncovered. Interventions through the natural helping networks served a preventive mental health function because they provided easily acceptable assistance before the occurrence of psychosocial breakdown. This book is divided into two sections: the first part provides a conceptual, historical, and empirical overview of natural helping networks, and the second part gives guidelines to professionals on working with such networks. Networks are viewed as tools to focus on the links between persons and families rather than on those units themselves. Such links are described in terms of the density, range, and durability of relationships within the network and in terms of the content and intensity of interaction. Network concepts and practices are traced to the origins of professional social work, especially "friendly visiting," early institutions serving as surrogate families, the settlement houses, and the community organization movement. The authors provide examples of current natural networks that developed in taverns, single-room occupancy hotels, and the Mexican-American curanderos. Artificial networks such as the widow-to-widow program and peer counseling in schools are also discussed. Guidelines and techniques for working with natural helpers and networks rest heavily on the consultation method. A step-by-step approach to locating natural neighbors and exploring the community and its resources is presented.

FIELD, SUZANNE. "Neighborhood Networks: Power in the Process," *Innovations* 7 (Spring 1980): 3-13.

This article describes the Neighborhood and Family Services Project directed by Arthur Naparstek and David Biegel. This is a research and demonstration project in Baltimore and Milwaukee that focuses on the strengths and helping resources of neighborhoods and creates linkages between community and professional networks. This approach replaces the catchment-area model with a "community mental health empowerment model," which seeks to understand coping and personal problem-solving by different groups in various neighborhoods. In Baltimore, the research component consisted of a needs assessment that also served to motivate the community to examine its own problems. This survey indicated that residents viewed family breakdown as the main community problem and that helping persons and agencies were fragmented with limited or nonexistent linkages. The goal of the service component was to develop a better working relationship among caregivers, agencies, and the community, which began with a citywide Neighborhood and Family Day to spread information about services and programs. Other aspects of services included establishing a task force to coordinate activities and provide assistance, initiating a volunteer-manned twenty-four-hour hotline, providing work shops on stress and family life, and developing a planning committee for monthly case conferences. In Milwaukee, a referral directory was published and self-help groups were sponsored. Three recommendations from the project are presented: (1) establish a federally administered self-help development fund to strengthen neighborhood support systems, (2) allocate manpower and service delivery demonstration funds to train and retrain mental health personnel to work with neighborhood support systems, and (3) allocate research money for further study of neighborhood support systems.

FROLAND, CHARLES, and PANCOAST, DIANE L. eds. *Networks for Helping: Illustrations from Research and Practice*, Proceedings of the Conference on Networks, November 1-2, 1978, Portland State University, Portland, Oreg.

This conference sought to address three issues regarding networks: (1) clarification of the meaning of networks, (2) understanding how networks affect client populations, and (3) integrating this information into practice. Part 1 presents illustrations from research that spans a range of problems and target populations and highlights the support provided by social networks. Included are studies of psychiatric patients, dialysis patients, and low-income elderly. As a group, the research papers indicate that the characteristics of the personal network available correspond to a person's health, adjustment, and use of formal services. The concept of networks is shown to be flexible and concise in describing complex patterns of relationships. Part 2 discusses networks in practice, with special attention given to natural, informal helpers, to self-help groups, and to the managing role of the professional working with such groups and helpers. Genuine respect for nonprofessional helpers is the sine qua non of successful collaborative efforts, and this is more easily achieved when the professional is comfortable with his or her own skills and role. There is general agreement that natural helpers can play a vital role in human services. The papers indicate that professionals are at a point where they can define, measure, study, and work with helping networks. Further research leading to a typology of networks is suggested.

GERMAIN, CAREL, ed. *Social Work Practice: People and Environments —An Ecological Perspective.* New York: Columbia University Press, 1979.

An ecological approach to the traditional social work person-situation formulation is advocated. This ecological perspective, which is also emerging in psychiatry, nursing, education, and psychology, takes an adaptive and evolutionary view of human behavior and focuses on individuals, families, and collectives in transaction with their environments.

The articles in the book are divided into three sections: practice applications, conceptual developments, and practice issues. In the first section, a range of settings and populations illustrates the application of ecological principles in social work practice. One paper discusses transactions between terminally ill patients and nonstimulating hospital environments. Another depicts the use of "wilderness therapy" to strengthen identity, competence, and autonomy among delinquents, and a third focuses on the social environment of aging persons. Other papers in this section apply the ecological perspective to family therapy, clinical services for women, and natural support systems.

The second section presents important conceptual developments related to the ecological perspective: the benefits of social networks and environmental action to mobilize and support mutual aid systems, the view of the extended family as a resource for change, the use of the genogram as a dynamic process to engage and map the family in time and space, the social functions of black language as an adaptive and coping maneuver related to a hostile environment, and the therapeutic potential of life events for creative adaptation and competence.

Broad practice issues are addressed in the last section. One paper calls for citizen participation to assure that societal organizations remain responsive to human needs and aspirations. Another discusses issues and tasks in the primary prevention of social problems. In this case, the ecological approach calls for the development of greater social competence and the continuing effort to promote the growth -

producing qualities of the environment. The last paper examines these issues in the context of a primary prevention program for delinquents that was based on a developmental model of social services.

KATZ, ALFRED H. "Application of Self-Help Concepts in Current Social Welfare," *Social Work* 20 (July 1965): 68-74.

The author focuses on the importance of enlisting the participation of the recipients of health and welfare services in many aspects of their care. Self-help groups are seen as a strategy for reaching lower socioeconomic groups and for overcoming problems in the delivery and utilization of needed services. Certain neighborhood residents can function effectively as nonprofessional helpers in a self-help structure, and clients or former patients can be utilized as cotherapists. The professional's role is seen as catalytic, not directing. Self-help forms are natural to the patterns of lower-class families and can act to remove or lessen the barriers between providers and recipients of services.

SILVERMAN, PHYLLIS R. "The Widow-to-Widow Program: An Experiment in Preventive Intervention," *Mental Hygiene* 53 (1969): 333-37.

The widow-to-widow program illustrated the effectiveness of the self-help group as a preventive modality. This approach emerged from a study of the normal grief process of widows in which the women reported feeling most comforted and best understood by other widows. A major program innovation was the use of "widow-aides" who offered friendship to the newly bereaved to lessen the risk of subsequent emotional disorders. The recruitment and training of these widow-aides is described.

_____. "Mutual Help Groups for the Widowed," In *Primary Prevention: An Idea Whose Time Has Come,* ed. Donald C. Klein and Stephen C. Goldston. Washington, D.C.: U.S. Government Printing Office, 1977.

Mutual help activities are described as a form of primary prevention. Primary prevention is seen not simply as a means of preventing an emotional problem, but also of improving people's capacity to master the dilemmas of living in a positive way. Experiences with mutual help groups for the recently widowed suggest that mutual help is a way of giving aid that does not require the individuals to define themselves as sick and become patients to be treated or cured. The role of the mental health professional in self-help groups is (1) to make referrals, (2) to become a consultant to existing groups, and (3) to help develop new groups. Five steps are given for forming new self-help programs.

_____. *Mutual Help Groups: A Guide for Mental Health Workers.* Washington, D.C.: U.S. Government Printing Office, 1978.

Mutual help groups are defined as people sharing a common problem coming together to help one another and as vital alternative services that perform a variety of mental health functions. To the extent that such groups reduce emotional distress or enhance ego strengths and social competence, they are forces for primary prevention. The key function of mutual help groups is that of "agents of transition," enabling persons to learn new roles and to adjust to new statuses. This occurs when the therapeutic processes of the group correspond to the phases of the transition. Three phases of transition are outlined: (1) the impact phase, an initial phase in which the group provides a sense of affinity to the individuals and enables them to acknowledge their distressing situation, (2) the recoil phase, during which the group provides specific information and shared coping strategies

about the condition or new role, and (3) the accommodation phase, in which individuals progress from the role of recipients to helpers. The author describes a wide range of mutual help groups and traces their emergence and development (1) to the professional failure to meet the needs of particular clients or patient groups, (2) to professional, especially medical, successes whereby accident victims and chronically disabled persons survive and must adjust to their handicaps, and (3) to rapid social change that has strained coping and adaptation. Also listed are four ways that mental health professionals can interact with mutual help groups: (1) making referrals to such groups, (2) serving as a consultant to the group's leadership, (3) serving as a member of the group's advisory board, and (4) initiating mutual help groups as a service strategy. The author concludes that professional groups and mutual help groups, when properly used, are complementary rather than competitive helping modalities.

VATTANO, ANTHONY J. "Power to the People: Self-Help Groups," *Social Work* 27 (July 1972): 7-15.

This article considers client power and participation as a social movement and discusses its clinical application (Alcoholics Anonymous, Synanon, Integrity Groups, and Encounter-Sensitivity Training Groups) and social application (Alinsky's Industrial Areas Foundation, Mobilization for Youth, and welfare rights organizations). The increase in client participation and the self-help movement is associated with (1) the population increase, which has compounded the chronic shortage of health and welfare professionals, (2) mounting evidence that professional services are sometimes ineffective, (3) increased recognition that official status and credentials do not guarantee competence, and (4) the success of self-help groups in bringing about personal and institutional change. Implications for practice and education are given, including the need for a partnership between professional and client in planning and providing services.

WEISS, ROBERT J., and BERGEN , BERNARD J. "Social Supports and the Reduction of Psychiatric Disability," *Psychiatry* 31 (1968): 107-11.

The authors hypothesize that the successful community adaptation of emotionally impaired persons depends on their receiving the culturally sanctioned "sick role." Thus, the social and psychological benefits of this legitimized sick role explain the low rates of psychiatric hospitalization among persons with visible, chronic physical handicaps. They present data from several surveys, including their own, to support this contention.

"Special Self-Help Issue." *Social Policy* 7 (September-October 1976).

This entire issue is devoted to the self-help movement, which is viewed as a way to improve human services practice and to meet unmet needs. Many of the articles demonstrate that the addition of the client as a resource makes self-help a potentially more powerful helping modality than traditional professional services. However, self-help services may cause problems by masking inadequate investments in social services and by distracting attention from societal inequalities and from wide-scale exploitation and oppression. It is worthwhile to review separately each article in this volume.

"Grassrooting the System" by J. Perlman is a study of sixty grassroots organizations, which were defined as associations involving local people mobilized on their own behalf around concrete issues of importance in their communities. A taxonomy of the grassroots movement is developed based on the origins, constitu-

ency, size, funding, and ideology of the various organizations.

"Women—Women Services" by the Women and Mental Health Project reports a field study that surveyed fifty alternative self-help groups and support systems for women. The report highlights the great variety in style of service, political ideology, accessibility of services, organization and staffing, services offered, and client characteristics.

"Self-Help and Mental Health" by A. Gartner reviews a variety of self-help programs in mental health, including the "anonymous" groups, Synanon and its offshoots, Recovery and other ex-patient groups, and the "living with..." groups. The role of the person who has survived the particular problem is the single most important common denominator of the various types of self-help groups. Such persons have experienced the problem and have learned the new coping role.

"How Does Self-Help Work?" by F. Riessman elaborates therapeutic aspects of self-help groups in mental health. These include the helper-therapy principle in which those who help others achieve a sense of mastery, the consumer-intensivity factor in which the mental health consumer participates in the quality of help received, and the professional dimension through which such problems as professional distance are eliminated via the self-help process.

"Self-Help and the Professional" by L. Borman analyzes the role of the professional vis-a-vis self-help groups and notes a shift in attitude leading to greater mutual acceptance. Attention is given to three characteristics of the self-help movement: the apparent widespread occurrence of groups, the groups' effectiveness for those who participate, and the fact that the movement is occurring outside the usual professional and institutional auspices.

"Youth Helping Youth" by J. Gordon and "Rap Room: Self-Help at School" by Robert Petrillo describe, respectively, a youth hotline and a "rap room" program. Both these self-help approaches rely on peer counseling services.

"Independent Living for the Disabled" by H. Kirshbaum et al. describes the development, philosophy, and activities of the Center for Independent Living in Berkeley, California. The center is a large, self-help, multipurpose community organization for the physically disabled. There is an emphasis on holistic health and developing support systems among the members. The mental health benefits include the sense of belonging and increased self-confidence and social competence.

"Helping Oneself to Health" by H. Marieskind analyzes gynecological self-help for women, beginning with an historical overview of such efforts. The dual goals of current gynecological self-help programs are to provide health education for women and to aid women in their own self-fulfillment. These are accomplished via the self-help clinic, a short-term group experience for the sharing of health information.

"Beyond Coping" by V. Sidel and R. Sidel expresses the view that unless the self-help movement is placed in the context of an appropriate set of broader social goals, it may inadvertently perpetuate and exacerbate current social problems, including the unequal and unjust distribution of resources and power in our society, the fragmentation of our communities, victim-blaming, and the ascedancy of technology over caring in our human services.

"Self-Care: An International Perspective" by L. Levin reports on the major self-care issues that were discussed at the Copenhagen Symposium, the first international symposium on the role of the individual in primary health care. These issues included philosophical and political issues; professional-lay relationships; economic, organizational, and administrative matters; ethics; legal issues; quality assurance and cost effectiveness; and policies and procedures. Research needs are analyzed and specific recommendations offered.

FAMILY LIFE EDUCATION

CROW, MAXINE. "Preventive Intervention through Parent Group Education," *Social Casework* 48 (1967): 151-62.

Parent education in small groups, a form of family life education, is viewed as an effective method to help parents with the tasks of child-rearing and to prevent various family problems. The emphasis on the educational format enhances parental self-esteem, and the group process broadens perspectives on child development and increases alternative ways of dealing with family situations. The key educational and preventive concept guiding the development of these groups and their choice of discussion topics is anticipatory guidance. A description of the agency's program is traced through the beginning, middle, and end phases of the group process.

GLASSER, LOIS N. "Family Services: Family Life and Sex Education," *Encyclopedia of Social Work*. New York: National Association of Social Workers, 1971.

The author describes family life education as an educative process with small groups that has the goal of imparting knowledge to strengthen family functioning and to prevent or minimize dysfunction. This process rests on three basic components: (1) voluntary involvement of participants, (2) emphasis on the educational approach, and (3) the professional assuming the role of expert. In addition to tracing the history of family life education, the article presents a suggested framework for the contents of two different approaches: one approach is for typical problems such as budgeting and childrearing, and the other develops content for families with special problems, such as having a handicapped member. Both approaches are based on the family life cycle and on the demands and transitions of various stages. Three important issues regarding social work and family life education concern the intrusion of personal values into the educational process, the sponsorship of family life programs, and the kind of training that would enable social workers to serve as educators.

National Commission on Family Life Education, National Council on Family Relations. "Family Life Education Programs: Principles, Plans and Procedures," *The Family Coordinator* 17 (1968): 211-14.

This report presents a framework for establishing and assessing family life education programs. The main purpose of such programs is to strengthen families by improving their capacity to cope with the stresses and demands of modern living. By helping families to better anticipate difficulties throughout the life cycle and by improving problem-solving skills, family life education attempts to reduce or prevent family breakdown and dysfunction. To develop a family life education program, the commission recommends (1) establishing a community family life educa-

tion committee, (2) establishing viable communications between concerned agencies, (3) assessing educational needs and priorities, (4) determining specific goals for the program, (5) assessing community conditions that affect family life, and (6) continual assessment and revision of the program. Criteria to consider in evaluating family life education programs and materials are provided. They include a broad definition of family life education as a basis for the program; active participation of students in determining course content and in class discussions; clarity, accuracy, and relevance in the information presented; and the respectful presentation of differing family values and life styles. In all areas, creativity and effective problem-solving are encouraged.

SIMON, DAWN. "A Systematic Approach to Family Life Education," *Social Casework* 57, (1976): 511-16.

Family life education programs can broaden the repertoire of services offered by family agencies. By strengthening the positive value of family living and promoting healthy relationships and communications, such programs attempt to prevent family breakdowns. The article stresses an educational rather than a clinical approach and discusses the major factors in planning such programs. These factors are identifying community needs, establishing the focus and themes of the program, recruiting group participants, developing a group structure, and determining fees. Details of several sessions of a sample group are provided.

STERN, EDGAR. "Family Life Education: Some Rationales and Contents," *The Family Coordinator* 18 (1969): 39-43.

The intense and rapid social and technological changes of modern society make it almost impossible to truly prevent family breakdowns. Instead, amelioration in the forms of direct treatment, family life education, and social action can help to lessen the extent and severity of family problems. Of these approaches, family life education in particular is seen as a force both for the preservation and reformulation of the role and function of the family. Family life education activities are carried out formally by educational, religious, health, and welfare organizations and agencies. Colleges and high schools provide the widest dissemination of knowledge about family living through courses in marriage and the family. The arts and public communications media, in a less formal manner, influence family values and patterns. In addition to the strong, open commitment to family life espoused by the educator, it is necessary to be fully knowledgeable about societal changes and pluralistic life-styles. This perspective enables the educator to understand the personal confusions and frustrations of persons not as manifestations of individual pathology, but as related to broad forces in the community.

WHITTAKER, JAMES. "Models of Group Development: Implications for Social Work," *Social Service Review* 44 (1970): 308-22.

Most theorists view group development as a series of phases through which all small groups progress. The author reviews these various formulations of group development found in the social work literature and concludes (1) that the Garland, Jones, and Kolodny model offers the most comprehensive approach, and (2) that other models may be used selectively to complement it. This information is also presented in table form to permit comparisons of the stages of each model.

The Garland, Jones, and Kolodny model consists of five stages. In Phase 1, Pre Affiliation, members struggle with approach-avoidance issues and often reveal their ambivalence toward involvement by vacillating in their responses to program

activities. During Phase 2, Power and Control, members view the group as potentially rewarding and beneficial. The leader is tested, a hierachy develops, and conflicts over autonomy, rebellion, and protection emerge. During Phase 3, Intimacy, members exhibit greater personal involvement with a more open expression of feeling and a growing ability to plan and cooperate in group projects. In Phase 4, Differentiation, members establish their individual roles, and clear communication and a sense of cohesion leads to greater autonomy for the group as a whole. In Phase 5, Separation, members respond to the group's termination with denial, regression, and reminiscing.

ADULT EDUCATION

KNOWLES, MALCOLM. *Self-Directed Learning: A Guide for Learners and Teachers.* Chicago: Association Press-Follett Publishing Co., 1975.

The purpose of this guide is to help learners and teachers improve their skills in self-directed learning. Part 1 advises the learner to establish the proper educational climate and to diagnose his particular learning needs. Four inquiry projects are outlined to facilitate self-directed learning. The first inquiry addresses the rationale for self-directed learning. Thus, in a rapidly changing society, information rapidly becomes obsolete, and education is not simply the transmitting of knowledge. Instead, the purpose of education through self-directed learning, is to ensure the survival of the individual by developing his skills of inquiry. The ability to learn on one's own — a basic human competence — has become a modern prerequisite for the survival of the individual.

The second inquiry focuses on the nature of self-directed learning. It is described as a process in which individuals take the initiative in diagnosing their learning needs, formulating learning goals, identifying learning resources, choosing and implementing strategies, and evaluating learning outcomes. The third inquiry consists of a self-rating scale regarding the competencies required for self-directed learning, and the fourth inquiry presents the "learning contract."

Part 2 of Knowles' guide is directed at the teacher, whose role must shift from content transmitter to learning facilitator. A variety of strategies by which to achieve this new role are presented, as are several illustrations.

Part 3 is comprised of exercises to promote learning and teaching: relationship building, consultation skills, self-assessment, questioning techniques and strategies, and the proactive reading of books, that is, selectively with forethought and deliberation.

_____. *The Modern Practice of Adult Education.* New York: Association Press, 1978.

This volume presents a comprehensive guide to the theory and practice of adult education, also known as andragogy. The central thesis is that since adults are different from young people as learners, a different approach to education is required.

The book is divided into three sections. Part 1 examines a variety of assumptions about the role of the adult educator, about the technology of andragogy,

and about learning and teaching in general. The mission of the adult educator is to develop a total environment conducive to human growth and fulfillment. To accomplish this, the educator must focus on the needs and goals of individuals, institutions, and society.

Andragogy as a technology is based on four characteristics that distinguish adult from child learners. In contrast to his younger counterpart, the adult learner is less of a developing, dependent personality; has accumulated a reservoir of life experience; is motivated to learn in relation to the tasks of his social roles; and is ready for rapid application of the new knowledge. Adult learning is more likely to be problem-centered than children's learning, which is subject-centered.

The general assumptions about learning and teaching are that (1) the basic ability to learn remains essentially unimpaired throughout the life span, (2) learning is an internal unfolding in relation to environmentally transmitted information, and (3) there are conditions and principles that can maximize both learning and teaching.

Part 2 is a how-to manual for applying principles of andragogy to the organization and administration of comprehensive programs of adult learning. One chapter is devoted to each phase of the andragogical process: (1) establishing an organizational climate and structure conducive to learning, (2) assessing needs and interests in program planning with community input, (3) defining learning purposes and objectives, (4) designing a comprehensive program based on the defined goals, (5) operating the educational program, and (6) evaluating the premises and effectiveness of the program.

Part 3 focuses on designing and managing learning activities for the individual. The management principles, course methods, and illustrations provided have been tested and are drawn from a wide variety of fields.

EPIDEMIOLOGY

CASSEL, JOHN M. "Potentialities and Limitations of Epidemiology," *Public Health Concepts in Social Work Education*. New York: Council on Social Work Education, 1962.

This paper traces the history of epidemiology as a form of scientific study. It concludes that the traditional germ-theory model of epidemiology needs to be modified to include assessment of social and cultural factors which influence the prevalence of disease. The paper provides a lengthy illustration of multicausation in the diagnosis and treatment of tuberculosis.

DOHRENWEND, BRUCE P., and DOHRENWEND, BARBARA S. "Psychiatric Epidemiology: An Analysis of 'True Prevalence' Studies," In *Handbook of Community Mental Health*, ed. Stuart E. Golann and Carl Eisdorfer. New York: Appleton-Century-Crofts, 1972.

This study attempts to explain the extreme variability in rates of psychiatric disorders as reported in forty-four community studies. Findings regarding the relationship between psychiatric symptoms and various social factors are summarized, and an in-depth discussion of the social selection-social causation issue is provided. The study also raises key questions concerning the methodology, in general, and the validity of measures, in particular, used in such studies.

_____. "Social and Cultural Influence on Psychopathology," *Annual Review of Psychology* 25 (1974): 417-52.

This article is a clear and comprehensive review of all known studies on the occurrence and distribution of psychopathology in general populations. Despite methodological problems in these studies, the relationships between various social and cultural factors and mental disorder are found to be highly consistent from study to study. The empirical status and pertinent findings regarding key issues are presented, and a highly imaginative research strategy is proposed to resolve the social selection-social causation debate.

DOHRENWEND, BARBARA S. "Social Status and Stressful Life Events," *Journal of Personality and Social Psychology* 28 (1973): 225-35.

This study examines the link between low social status and individual psychological distress. Analysis of the data in this community survey indicated that members of the lower social class and women are disproportionately exposed to stressful life events. This greater exposure accounts for psychological distress among women and, to a lesser extent, among lower social class persons. In contrast, Blacks and Puerto Ricans did not experience a disproportionately high exposure to stressful life events. Because of methodological problems, the finding that ethnicity as such does not impose a further burden of psychological distress beyond that imposed by low social class, should be viewed cautiously.

FRIED, MARC, and LINDEMANN, ERICH. "Sociocultural Factors in Mental Health and Illness", *American Journal of Orthopsychiatry* 21 (1961): 87-101.

Research and practice in the field of mental health and illness has been hampered by the focus on psychopathology and by the neglect of sociocultural factors. This omission strongly affects the emergence, definition, and treatment of psychological disorders, as illustrated by the authors' preliminary findings in their study of poor and working-class families who were forced to relocate by an urban renewal program.

GRUENBERG, ERNEST. "Epidemiology of Mental Retardation", *International Journal of Psychiatry* 2 (1966): 78-127.

A comprehensive overview of the epidemiological literature in the field of mental retardation is presented. The article provides a general orientation to the methodology and purposes of such studies and reviews major landmarks in research on mental retardation. Two new approaches to collecting epidemiological data are described: one is a mental disorders register to classify known cases in a given population; the other is a periodic survey of the health problems of samples of the community.

HAMOVITCH, MAURICE B. "Epidemiology: Its Application for Social Work," In *Public Health Concepts in Social Work Education: Proceedings of Seminar held at Princeton University, Princeton, N.J., March 4-9, 1962,* New York: Council on Social Work Education in cooperation with Public Health Service, 1962.

Although the methods and objectives of social work research were found to be highly compatible with epidemiologic principles, such research was noted as lacking in two areas: the development and testing of hypotheses, and the systematic validation of programs. The article reviews the basic terminology and concepts of public health and their application in social work practice to multicausal psychosocial phenomena. The history of epidemiologic efforts in social work and social welfare

is highlighted.

KRAMER, MORTON. "Problems in Psychiatric Epidemiology", *Proceedings of the Royal Society of Medicine* 63 (1970): 553-62.

This article identifies the gaps between the statisical data required for the successful implementation of community mental health legislation and the currently available statistics and methodologies. Cited are two limitations of the epidemiologic approach in mental health research: (1) the absence of standard case-finding techniques, and (2) the lack of guidelines to specify diagnostic categories. These limitations are illustrated in a discussion of the goals of community mental health programs.

LEIGHTON, DOROTHEA C., and LEIGHTON, ALEXANDER H. "Mental Health and Social Factors," In *Comprehensive Textbook of Psychiatry,* ed. Alfred M. Freedman and Harold I. Kaplan. Baltimore: Williams & Wilkins, 1967.

The major biosocial variables found in population studies of mental illness and health are highlighted through examination of a series of population research studies using the epidemiologic approach. These variables include culture, sex, age, marital status, socioeconomic status, and sociocultural integration. The usefulness of the epidemiologic approach in studying known and unknown psychiatric conditions is emphasized.

LILIENFELD, ABRAHAM. *Foundations of Epidemiology.* New York: Oxford University Press, 1976.

This textbook is intended as an introduction to epidemiology, which may be defined as the study of the distribution of physiological diseases among humans and the factors that influence this distribution. Historical and current emphases in the epidemiologic approach to disease are presented along with selected concepts, such as agent, host, and disease process. The use of mortality and morbidity statistics is described, with ample research illustrations in those two areas. In addition, separate chapters are devoted to prospective, retrospective, and cross-sectional studies. There is also discussion of experimental epidemiology utilizing controlled studies and of theoretical epidemiology, which relies on the development of mathematical formulations to predict relationships between variables. The book emphasizes the role of the epidemiologist as an integrator of knowledge from a variety of scientific disciplines.

MACMAHON, BRIAN and PUGH, THOMAS. "Suicide in the Widowed," *American Journal of Epidemiology* 81 (1965): 23-31.

This epidemiologic study examines whether bereavement is a significant etiologic factor in the high suicide rate observed among widows and widowers. The basic methodology is to determine whether suicides among widowed persons cluster in time following the death of their spouses. Following extensive analysis of statistical data, the conclusion is reached that the risk of suicide among the widowed is higher in the first four years of bereavement than in later years and is particularly high during the first year of bereavement. Findings also indicate that the risk of death from suicide, as compared to the risk of death from other causes, is greater in the first four years of widowhood, and particularly high in the first year.

TERRIS, MILTON. "Approaches to an Epidemiology of Health," *American Journal of Public Health* 65 (1975): 1037-45.

This articles provides an overview of the concepts and interrelations of health, illness, and disease. The central theme is the utility of the epidemiologic method for studying health in contrast to its usual use for the determination of disability. Several approaches are described and evaluated, and illustrations from areas such as nutrition, labor, and physical and mental development are provided.

EVALUATION

BLOOM, BERNARD L. "Evaluating Achievable Objectives for Primary Prevention," in *Primary Prevention: An Idea Whose Time Has Come*, ed. Donald C. Klein and Stephen C. Goldston. Washington, D.C.: U.S. Government Printing Office, 1977.

The author initially reviews some of the distinguishing characteristics of the field of community mental health: (1) practice in the community rather than in an institutional setting, (2) a population or total community orientation, (3) a preventive service focus rather than on therapeutic services, (4) comprehensiveness and continuity of services, (5) indirect rather than direct services, (6) an emphasis on innovative clinical strategies, (7) rational planning, (8) the innovative use of new sources of manpower, (9) a commitment to community involvement, and (10) the belief that the community has certain counterproductive, stress-producing forces rather than that the individual is the exclusive source of psychopathology.

Following this initial review, the author defines the task of evaluating primary prevention programs as determining how much success is achieved by a particular program in accomplishing a predetermined set of objectives. Both the program and its objectives must be specified in advance, and multiple objectives should be arranged in a hierarchical order. Evidence must be presented to show that the program is the cause of the change in the recipient group. The relationship between the application of the technology and the attainment of the objectives must be clearly demonstrated. Statements about program objectives must be converted to observable, measurable criteria in order to determine the amount of success. Four types of program evaluation are discussed: (1) the narrative account, which is actually a program description, (2) evaluation based on judgements made by the recipients of the program, (3) evaluation based on judgements made by the providers of service or by outside experts, and (4) evaluation based on analysis of objective community data without interpretive judgements.

FLANGAN, JOHN C. "Evaluation and Validation of Research Data in Primary Prevention," *American Journal of Orthopsychiatry* 41 (1971): 117-23.

Five factors deemed critical to the validity of primary prevention studies are reviewed. First, the characteristics of the experimental group must be carefully described since the sampling procedure is the primary determinant of the extent to which findings can be generalized to other groups. Second, the experimental treatment must be defined in explicit detail, including the nature of the intervention and the qualities and training of the staff; a clearly defined program with a theoretical rationale and a stated hypothesis regarding the anticipated effect of treatment should be presented. Third, the criteria of any evaluation must be based on program objectives, and a distinction should be made between ultimate criteria

(outcome, change) and intermediate criteria. Fourth, a simple descriptive analysis of the research data and an attempt to replicate the findings are more likely to produce correct and convincing interpretations of a program's outcome than would an involved statistical treatment of one set of research data. Fifth, since shortcomings in any of the previously named factors affect the inferences, generalizations, and conclusions, it is always important to indicate the limitations in the data.

CRITICISM AND LIMITATIONS OF PRIMARY PREVENTION

BROSKOWSKI, ANTHONY and BAKER, FRANK. "Professional, Organizational and Social Barriers to Primary Prevention," *American Journal of Orthopsychiatry* 44 (1974): 707-18.

This paper provides a comprehensive review of the literature on barriers to the design and implementation of preventive programs. Four categories of such barriers are formulated: (1) the difficulties in applying the public health levels of prevention to mental health phenomena, (2) insufficient appreciation of the complex systems and ecological forces affecting mental health phenomena, (3) the inability to demonstrate program effectiveness because of inadequate research methodologies, and (4) the lack of public demand for preventive efforts. Suggested remedies to these problems include the use of preventive models emphasizing health promotion, greater application of general systems theory, and training professionals as research and development specialists.

CUMMING, ELAINE. "Primary Prevention: More Cost Than Benefit," In *The Critical Issues of Community Mental Health*, ed. Harry Gottesfeld. New York: Behavioral Publications, 1972.

The author criticizes the use of crisis intervention and consultation as strategies for the primary prevention of mental illness. Both approaches lack researched proved effectiveness and remove needed manpower from the direct treatment of the mentally ill. In addition, she emphasizes that the social problems of the society have not been demonstrated as causes of mental illness and are not within the domain of the training and competence of psychiatrists. Social problems such as poverty and slum living are intolerable conditions and should be viewed as untenable in their own right.

LAMB, H. RICHARD, and ZUSMAN, JACK. "Primary Prevention in Perspective," *American Journal of Psychiatry* 136 (1979): 12-17.

This article argues that the field of primary prevention rests on unclear conceptual premises and untested assumptions. For example, the prevention of major mental illness rests on a developmental continuum view of psychopathology that is questionable in the light of increasing evidence from genetic research. The lack of a demonstrated causal relationship between environmental stresses and mental illness raises questions about the usefulness of large-scale societal and community interventions. Moreover, since the relationship between rates of mental illness and child-rearing practices, mental health education, crisis services, or programs to promote social competence remains unestablished, preventive practices in these areas are viewed as having doubtful value. The conclusion is reached that until

empirical evidence is available regarding the effectiveness of primary prevention, mental health funds should not be diverted from direct treatment of the mentally ill.

WAGENFELD, MORTON. "The Primary Prevention of Mental Illness: A Sociological Perspective," *Journal of Health and Social Behavior* 87 (1972): 282-88.

A review of epidemiological literature suggests that since the relationship between mental illness and social problems is unproved, primary prevention is based on an ideological rather than an empirical foundation. The major ideological assumption—that the psychological functioning of large segments of a population can be altered through changes in the social structure— has not been validated in sociological and social psychological research. The author suggests that community mental health efforts should follow two directions: correcting gross inequities in the mental health delivery system and developing empirical studies to test the assertions and assumptions that have characterized much of primary prevention.

VAN ANTWERP, MALIN "The Route to Primary Prevention," *Community Mental Health Journal* 7 (1971): 183-90.

A survey of the attitudes of mental health professionals in leadership positions indicated that these professionals' strong support for primary prevention was an integral part of community mental health programming. This support is maintained even when the effectiveness of preventive activities cannot be demonstrated in advance. Despite the significant value these administrators place on preventive services, there are only a limited number of preventive programs. The reasons for this incongruity were identified as (1) limited expertise and professional agreement regarding comprehensive social planning, (2) reluctance of public officials to increase funding to facilitate social action programs, (3) lack of public, legislative, and professional appreciation that long-term tertiary care is more expensive than preventive intervention, and (4) inadequate professional education regarding primary prevention. It was concluded that a combined professional and legislative effort is necessary to gain broad community support for primary prevention programs.